Working paper research project 'history of health systems in Africa': swiss mission hospitals and rural health delivery in the 20th century (SNIS final report)

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Abstract: The main aim of the project was to contribute to a better understanding of health services in developing countries through Swiss Missions by using historical research methods. The research is based on two case studies located in Ghana (Agogo Hospital: Basel Mission) and South Africa (Elim Hospital, Mission Romande). The research team was especially interested in examining the interaction between health care providers and their changing political, social and economic environments. They studied the activities of former Swiss missionary hospitals and the changing conditions under which they delivered various forms of health care. The ultimate aim is to show how history can contribute to the development of sustainable health systems. Historical explanations for the success and failure of health systems can serve to inform today's decision-makers. The study applied the methodologies of history and social anthropology, as well as (historical) epidemiology in order to examine the effects of political, economic, social and cultural changes on disease and health environments.

Other titles: A history of health systems in Africa: Swiss mission hospitals and rural health delivery in the 20th century

SNIS Final Report: Working Paper

Research Project 'History of Health Systems in Africa'

Introductory Part to the Working Paper

This scientific report outlines the comparative history of rural hospitals which were built and developed by three Swiss missionary societies in Sub-Saharan Africa. The three case studies from South Africa, Ghana and Tanzania have produced self-standing results concerning the research aims defined by the 'History of Health Systems in Africa' project research frame. This throws light on the transnational history of Switzerland and on the meaningful role played by former Swiss missionary health institutions and their representatives in the development of rural health care systems in Sub-Saharan Africa. This study does not primarily aim at writing a history of three Swiss mission hospitals, but at producing an analysis of their very different actors and their practices as well as their various health policies and strategies over time and in different African contexts and environments. Several major findings were produced and different nodal points have arisen; nevertheless, this report analyses and compares the most prominent ones which have mainly emerged in the still on-going research process: the (shifting) historical and political context of the development of Swiss mission hospitals (Section I); the (changing) characteristics and representations of these health institutions in Sub-Sahara Africa (Section II); their (moving) main actors and their (varying) impact on hospital-related rural health care (Section III).

Section I:

Roots of the Mission Work in Sub-Saharan Africa: the Evangelical Movement in Europe

The transnational history of Switzerland and its connection to Africa is closely linked to missionary work. Actually, many Swiss missionary activities in African countries such as South Africa, Ghana and Tanzania[1] are rooted in early 19th century Protestant evangelism. This movement aimed at a 'revival' of Christianity and, accordingly, it spread into newly discovered parts of the world. Thus, many Protestant churches in Europe became involved in founding mission societies, mainly from the late 18th and over the 19th century. So, missionary societies such as the Baptist Missionary Society (1792) and the London Missionary Society (1795) were established in Great Britain (Gelfand, 1984), and the Société Évangelique des Missions de Paris was founded in France in 1822. Switzerland took up its own missionary work in the early 19th century with the creation of the Basel Mission in 1815; an evangelical missionary society was established in Lausanne in 1826 (Harries, 2007). Over time, Swiss missionary societies drew their support and staff mainly from Basel, Geneva, Lausanne and Neuchâtel, as well as from south-western Germany and eastern France. A separate Mission Vaudoise emerged out of this movement in 1875.[2] After the Protestants' movement, the Catholics joined this process. The Swiss Province of the Capuchin Order started its missionary work in Tanzania in the 1920s. In fact, this order had received some of the territories left by German Benedictine missionaries after the demise of German colonialism in East Africa (Haller, 1997).

The origin of the Swiss mission in Southern and South Africa goes back to a request (dated 20 May 1862) for missionary work issued by two students of theology: Ernest Creux and Paul

[1] This is true in Tanzania, for instance, for the evangelical Moravian Church, but not for the Roman Catholic mission.
[2] DMR Archives. Bulletin de la Mission Vaudoise, vol. 1, 1875, pp.1-8.

Berthoud. The Commission of Missions created within the Free Church of the Canton de Vaud approved in 1869 the establishment of a separate mission. The convention was ratified at the Morges Synod on 2 November 1871. Ernest Creux and Paul Berthoud were consecrated to their ministries on 21 January 1872 in Lausanne and 8 September 1872 in Morges respectively[3]. They were sent to serve the Paris Evangelical Missionary Society in Lesotho where they arrived in the same year (1872). The following year, after exploring a possible extension of the missionary work of the Lesotho Churches among the Bapedi, the two Swiss ministers came across a group of refugees whom they called 'Tsonga' (Butselaar, 1984; see below). In 1875, they bought a farm in the northern Transvaal where they established their first mission station at 'Valdezia', a location named after their canton of origin: Vaud. Albeit the choice of this location seems not to be premeditated, the Swiss soon loved the area and respected its inhabitants. In Switzerland, delegates from Geneva and Neuchâtel joined the Vaudoise Commission of Free Churches ('Commission de Mission Vaudoise') in June 1883. This new body soon took the name of Council of the Romande Mission ('Conseil de Mission de la Suisse Romande'). By this, the Mission Vaudoise changed to become the 'Mission des Églises Libres de la Suisse Romande' (Swiss Romande Mission of Free Churches).

The desire to spread the word of God, as expressed in Matthew 28, 18-19, led Swiss missionary societies, as other European ones, to initiate a long-lasting, intensive and not always unambiguous relationship with Africa, and particularly with countries such as the Gold Coast (present-day Ghana), the Transvaal (South Africa) and Tanganyika (Tanzania). But as this research reveals, there are not only religious-charitable motives as driving forces behind this 'sense of mission', but also (to a great extent) secular reasons and individual ambitions.

Historical Context in South Africa, Ghana and Tanzania

The major Swiss mission field of action in Southern Africa was located in the Soutpansberg District of the northern Transvaal: it spread to southern Mozambique in the early-mid 1880s. At this time the Soutpansberg District was part of the old South African Republic (1852-1877 and 1881-1900). Here, the administrative and political control moved finally from Boer to British hands in 1902[4]. Early legislation which aimed at improving the health of the population in this region included the Public Health Act of 1889 and the Medical and Pharmacy Act of 1891.[5]

At that time the provided health service was already perceived as an urban venture, segregated and almost non-accessible to rural people, particularly the so-called 'natives'.[6] There was no health facility in the rural northern Transvaal, the poorest frontier of the South African Republic. However, medical help was provided at the Swiss Mission station founded in 1879 at Elim. Other social institutions were set up by the Swiss. Bible schools for local people started at those early times at both Valdezia and Elim.[7] In the late 1890s, the Swiss Mission turned to the health needs of the rural inhabitants of the region with the establishment of a hospital at Elim.[8] Georges Liengme, the first Swiss missionary doctor, returned to Switzerland to look

[3] Giyani Archives. Creux, E., Minutes of the Spelonken Conference at Elim, 8-11 January 1906, p.4.
[4] The Union of South Africa (1910) following the Second Anglo-Boer War (1899-1902) helped to 'stabilize' the political situation of the country, as the Transvaal became one of the four provinces within the Union. It was only in 1961 that the Republic of South Africa was proclaimed.
[5] Giyani District Archives. Mopany Municipality. Public Health Bills, 1889, 1891.
[6] Laidler, P.W. and Gelfand, M., *South Africa. Its Medical History, 1652-1898*, Cape Town, Struik, 1971, p.483. The authors mention that "[b]y 1898, the Transvaal was served by 287 registered doctors, veterinarians and six dentists". But these doctors were acting mostly in Johannesburg and Pretoria, at Potchefstroom Hospital, Pretoria Lunatic Asylum, and Pretoria Leprosy Hospital.
[7] DMR Archives Lausanne. 2.4: Oeuvre de la Mission Romande au Transvaal en 1887. Rapport de la Conférence adressé au Conseil par Mr. Thomas, 1888.
[8] DMR Archives Lausanne. 5.1. Hôpital d'Elim, Rapports, 1897, 1899-1900.

for funds for that purpose (Liengme, 1906). He came back to Elim with the necessary financial means for the building of the first Swiss missionary hospital in Southern Africa.

The first activities of the Basel Mission in West Africa date from 1828. Until the end of the 19th century the mission activities remained restricted to the wider hinterland around Accra. Its expansion to the Ashanti area - were Agogo hospital is located - took place at the beginning of the 20th century. Until that time the Basel Mission had already acquired an important social role and a good reputation in the Gold Coast, especially with regard to education. But World War I terminated the Basel Mission's enterprise, as all (Swiss) missionaries were expelled from the British colony. The Scottish Mission and the Presbyterian Church of the Gold Coast, founded in 1918, took over the Basel Mission's activities. When the missionaries returned to the Gold Coast in 1926, their work was restricted by the Scots' and the Presbyterian Church's influence and, geographically, bound to the Ashanti area.

In Tanganyika, the historical context in the early 20th century was particularly marked by movements of resistance such as the Maji Maji Insurgency in 1905 (Larson, 1976; Monson, 2010). Swiss Catholic missionaries under the Capuchin Order and the Sisters from Baldegg reached the former German colony only after World War I. Traces of the ravages caused by the military conflicts were still prominent. The early missionary work had been destroyed. However, this severe disruption resulted in the reshaping of both political and economic structures after 1919.

A year after the British mandate was pronounced by the League of Nations in 1920, the Capuchin Mission could start its work. However, the Swiss missionary work emerged in a context of acute social and political change. The activities of the first missionaries were oriented towards rural areas[9] where they found great needs and little means.[10] The range of services offered by these missionaries was not only spiritual and pedagogical, but also medical: Christian missions soon acquired a reputation as conveyors of European medical science (Etherington, 2005).

Medical Mission

The Church felt called to undertake the healing and care of both body and soul. Indeed, since the beginning, most missionaries received a medical training enabling them to deal with health concerns in the mission field. That was certainly true for the early Swiss missionaries who received a brief and elementary training in medicine in Edinburgh before departing for the Transvaal. Edgar H. Brookes recalled in the 1920s that "*from the earliest days, the Swiss missionaries received at least an elementary medical training, but it was not until 1891 that the first professional Doctor arrived in their field*"[11]. However, the medical practice within missions was a significant – and debated – issue for most missionary societies as early as the 1880s. Tensions soon arose about creating the missionary doctor position. Indeed, in spite of their elementary medical training, missionaries such as Paul Berthoud were not really willing to spend time and energy in that secular activity. Moreover, there were also members of the Swiss mission's headquarter in Lausanne who considered the appointment of a medical doctor

[9] The reasons for selecting rural areas as their primary 'target location' are manifold and vary from mission to mission, from place to place and from time to time: ideological-religious mission policy to help the poorest, most isolated and most marginalized people; many missionaries showing themselves an agrarian background; being called by local leaders; preventing competition with other missions; avoiding the 'spoilt modern way of life' of urban communities; eluding the control of colonial administration; or, conversely, pioneering colonial administrative expansion; and the then notion of 'the mission to the pagans' aiming explicitly at a rural population with 'traditional beliefs'.

[10] We should keep in mind that the first missionaries were also suffering from different precarious conditions.

[11] Brookes, E.H., *Fifty Years of Missionary in South Africa: 1875-1925. Swiss Mission to Shangaan Tribes. A Retrospect and a Forecast*, p.12.

as a waste of money for an evangelical institution. Nevertheless, the same mission council in Lausanne decided in 1886 that a medical doctor would improve and complement the evangelical task of the Mission.

Consequently, a young man from Cormoret, a small village in the Bernese Jura, Georges Liengme, received support for his medical studies in Bern, and then in Geneva, where he graduated in 1890 and was consecrated a year later in Geneva. The following year he left for the missionary field. After misadventures in Mozambique where he served as the personal medical doctor of the African Chief Ngungunyane, Dr Georges Liengme reached Shiluvane in the Transvaal (South Africa) in 1896 before he joined Ernest Creux at Elim.[12]

As early as 1880 the Basel Mission committee, with its long experience of the field in Africa, had initiated discussions around the establishment of a 'medical mission' ('Ärztliche Mission'). In 1885, the physician Rudolf Fisch left Basel for the Gold Coast. His priority was to provide medical care for the missionaries, but also for the 'heathen'. He first opened a sanatorium for Europeans, and later a small clinic for the Africans in Aburi (north of Accra) which expanded later into a small hospital by the beginning of the 20th century.[13]

Development of Swiss Hospitals in Rural Africa

Elim Hospital in the northern Transvaal (South Africa) is the oldest hospital established by the Swiss mission in Southern Africa. In 1899, Georges Liengme officially opened Elim Hospital. A new ward dedicated to white patients was inaugurated in 1900[14]. As a result, there were two wards: one for African patients and another one people of European descent. For 50 years, Elim remained the only hospital in this rural area, providing health care to all people regardless of class, race and religion. During the Anglo-Boer War (1899-1902), Elim Hospital was involved in the care of both the British and the Boer soldiers.

This small Swiss hospital had to face several endemic and epidemic diseases such as malaria, the venereal diseases and tuberculosis brought from the cities and, in 1918, the great Influenza epidemic.[15] The hospital grew rapidly due to increasing health needs within an area where there was no health facility up to the mid-20th century. The hospital also registered a change in the patients' health profile when, in the 1930s, eye diseases started becoming a growing concern. Soon, the Swiss hospital became well-known over the country and even abroad due to the high standard of its health service delivery, its quality of care and the fact that all its professional medical staff came from abroad to care for patients in the tiny village of Elim in one of the poorest parts of the country. The particular political contexts of Segregation (1913) and Apartheid (1948) participated in shaping the Swiss health institution into a place of hope for reliable care for many formally excluded patients within a country marked by institutionalised racism. Actually, Elim Hospital became the point of departure for a Swiss mission health care system while some of the missionary health facilities which were built later by the Swiss, became hospitals. Thus, in the 1940s, the Swiss mission society in South Africa had nine health institutions including the three hospitals of Elim, Masana and Shiluvane.

[12] Château de Penthes Archives. Liengme: Correspondences.
[13] Fischer F.H., Der Missionsarzt Rudolf Fisch und die Anfänge medizinischer Arbeit der Basler Mission an der Goldküste (Ghana), Herzogenrath, Murken-Altrogge, 1991. This reference is particularly interesting for the history of Basel Mission prior to World War I.
[14] Elim Hospital Archives. Elim Hospital: Buildings.
[15] Elim Hospital Archives. Patients' registers, 1900-1934. The analysis of these mines of information shows that in the early 1900s malaria was particularly prominent among the whites while other communicable infections such as venereal diseases and dysentery were more common among the Africans.

By this time the construction of hospitals and the provision of health services for local people had become an important part of the activities of the Swiss missions in rural Africa. This missionary medical work was also an on-going process in other political and geographical contexts in the early 20th century. After resuming its activities on the Gold Coast in 1926, the Basel Mission decided to build a hospital in 1927. Agogo was not the first choice for the site, but others location were rejected by either the Scottish Mission or the colonial government.[16] Official oral history in Agogo assigns a prominent role in 'getting' mission and hospital to the then-ruler, the Agogohene. This active role of Agogo's traditional leadership is connected to three kinds of explanation. Firstly, it fits the town's and its leadership's (then and today) reputation as a 'showcase' in terms of 'development'.[17] Secondly, the Agogohene's efforts are put in connection with long-lasting conflicts with the neighbouring Bompata, which goes back to different positions taken on the war between Ashanti and the British, and the consequent rearrangement of the 'native' political landscape in Ashanti by the colonial government. Thirdly, the success in attracting the hospital is traced back to a long-term relationship between Agogo and the Basel Mission connected to the journey in captivity of the famous missionary Friedrich Augustus Ramseyer and his wife – an explanation also shared with the church's account of the foundation of Agogo.[18] When it was inaugurated in 1931, Agogo Hospital was the only biomedical health care facility in the Ashanti-Akim District, and the only substantial hospital run by a mission in the entire British colony. Due to World War II – the majority of the medical staff was German, and thus interned by the British – the institution closed its doors in 1940. After the war the hospital was reopened in 1947.

In the late 1930s the Swiss Capuchin Mission took over the government hospital in Mahenge as its first proper missionary hospital in Tanganyika.[19] Due to conflicts with the missionary doctors, this enterprise turned into a disappointing experience. At Ifakara, however, things developed more successfully. Here Sr. Arnolda Kury, from the Franciscan Baldegg congregation of the "Schwestern der göttlichen Vorsehung" built a small dispensary in 1927. This facility developed over the years and grew considerably when the St. Annaheim maternity hospital was added in 1944. The first trained surgeon was appointed in 1951; Dr Karl Schöpf replaced him in 1953. He designed and built a modern and new hospital, now called St. Francis Hospital, with support from Sr. Arnolda, the powerful parish priest and not least the Capuchin Bishop of the Archdiocese of Dar es Salaam. Dr Schöpf remained in service at St. Francis Hospital in Ifakara for 17 years.

Secularization and Integration of Swiss Mission Hospitals into National Health Services

The secularization of mission health care facilities in the framework of Swiss mission activities can be seen as the process of the takeover of mission institutions by local states and government authorities in Africa. This meaningful shift of responsibilities and rights from the hands of spiritual bodies to secular ones started after World War II.

In South Africa, in particular the issue of a better control of mission hospitals became an important matter for the National Party that won the national elections in 1948. State control was

[16] National Archives, Accra, Ghana: ARG1/3/3/40, Public Records and Archives Administration Department (PRAAD), Kumasi: "Ohene of Agogo to District Commissioner Juaso," December 1927; ibid., "Secretary Basel Mission to District Commissioner Juaso," January 2, 1928; ibid., "DMS to Chief Commissioner, Ashanti," September 3, 1928. Basel Mission, D-4-2-1, Carl B. Huppenbauer, "Annual Report 1931/32 (to Medical Department), 1932; Basel Mission, D-4-6-2, "Huppenbauer vor Komitee," February 14, 1934.

[17] This opinion is also found in colonial sources.

[18] Nana Akuoko Sarpong, interview by Pascal Schmid, February 17, 2009, Accra; Nana Yaw Aburam, interview by Pascal Schmid, trans. Yakubu Ismailia, January 14, 2010, Agogo New Town.

[19] Tanzania National Archives 26367. Acc 450/HE/178/16; Acc 461 16/8 Vol I and 16/9; PAL Sch 1061.

an essential part of these new policies (Ijsselmuiden, 1984). In this context, missionary health institutions appeared as spots beyond the state's control. Consequently, the state had to react: firstly, and following the advice of its strategists, the South African state started to increase its financial contributions to the budgets of mission hospitals in the 1950s and to gain control by this move. A second strategy – or more a trial or test – by the South African state was the removal of certain mission hospitals from their original locations. Thus, in 1961, the Swiss mission in Southern Africa received the order to remove their main hospital from Elim village[20]. Later, the state decided to negotiate the takeover of the missionary hospital through formal purchase. This was achieved in the early 1970s under the condition that missionary health workers could remain in the hospitals – and that they could even be transferred to any hospital of their choice. The hospital's budget was now provided by the state and the former missionaries became civil servants. This takeover became effective at Elim in 1976.[21] The hospital was integrated into the National Health System but under the government of the government of the Gazankulu bantustan. This leading role attributed to the Gazankulu Government was justified by both the fact of its geographical location and the 'historical' relationship between the Swiss missionaries and the Tsonga-speaking people. The apartheid policy viewed Gazankulu as the political 'homeland' of the Tsonga 'ethnic group'.

In other Swiss missionary fields, rather than the secularization as defined above, the trend was increasingly set to integrate mission hospitals into the colonial/national health services after World War II – rather than the secularization we have met in South Africa. Indeed, even in Tanzania where the Swiss felt impelled to run the government hospital of Mahenge in the 1930-1940s, things changed. Swiss missionaries continued running their institutions, as the 1950-1960 period was still a period of autonomy and power. But, even though hospitals remained under the ownership of spiritual bodies, meaning local churches after the end of the 'missionary era', these churches were increasingly losing their autonomy and sovereignty as health care providers. Indeed, in Tanzania as well as in Ghana, new players entered the field. Firstly, the colonial state aimed to augment its intervention in the field of health during that long period of transition started after 1940 (Cooper, 2002). Later, in Ghana, the Presbyterian Church of Ghana (PCG) took over all medical facilities from the Basel Mission. In Tanzania, conflicts arose about the cost of St. Francis Hospital. The diocese of Mahenge was split from the Archdiocese of Dar Es Salaam and the Swiss became simple partners. By this time the new African elite wanted to prove its ability to manage health concerns; and international organizations also became increasingly active in helping these new independent states to devise health policies. By the end of the 1970s, the hospitals at Agogo and Ifakara were formally integrated into the local and national health care systems.

Funding Missionary Medical Work

Since the beginning of the medical work undertaken by Swiss missionaries in Africa, the issue of funding appeared significant. Indeed, tensions about the medical role of missions, as early as the 1880s were connected to the fear of spending too much money for non-evangelical activities.

The South African case has shown that the Transvaal administration wielded strong and well-organized local power in its relations with the Swiss missionaries. When Dr Liengme asked for permission to build a hospital in the Soutpansberg District, permission was granted on condition that the hospital had to serve both African and white patients. Moreover, the Transvaal government offered to fund the construction of the hospital. Nonetheless, Dr Liengme chose to return to Switzerland to get the necessary funds from his missionary headquarters.

[20] Elim Hospital Archives. Elim Hospital memorandum, 1963.
[21] Gazankulu Legislative Assembly, Debates, Volume 10, Special Session 1 September 1976, p.501.

This move was a strategic one as it aimed at keeping the hospital independent from the local administration. As a result, the hospital was financed by money raised in Switzerland.

But soon, increasing health needs led the hospital to look for yet more funds. Finally, soon after the British takeover of the Transvaal, an annual grant of £400 (CHF 10'000) was extended by the Transvaal government.[22] In the second half of the 1920s, that financial support was about £ 1'500. The grants grew over time up to the Missionary Institutions Fund Act of 1935. This provided Elim with a supplementary amount of £ 600 to subsidise the African section of the hospital[23]. This was both a kind of "signes avant-coureurs", signalling a willingness to organize health services at the national level, and a systematisation of segregated hospital finances.[24] Another phase was achieved 13 years later when the National Party won the elections and decided to introduce apartheid. Aiming to fully segregate the daily lives of South African people, this political system did, however, substantially increase the financial support given to the missionary work among Africans in rural areas. This allowed rural health facilities were able to grow appreciably.

At St. Francis Hospital, in Tanganyika, it seems that there was at no time any engagement of the government in infrastructure. The investment came entirely from the mission – while running costs were spread between the mission, the government and the users. Since the 1940s grants-in-aid have supported health service delivery by missionary organisations. The Swiss Capuchins were probably one of the weakest actors in this field in the 1940s and one may speculate that their commitment to the hospital sector was strongly shaped by the higher status of hospital medicine.

At Agogo, soon after the opening of the hospital, the issues about funding led to a severe conflict between the mission leadership in the Gold Coast and Basel, on one side, and the mission doctors in Agogo on the other side. At the centre of this dispute stood the strategic orientation of the hospital. Though Agogo Hospital never reached this goal prior to World War II, the hospital was considered, and was expected to be, financially self-supporting.[25] Later, in the view of the mission house in Basel, Agogo had even to generate revenue that could be invested into other missionary activities.[26] Nonetheless, the strategy of the hospital management was oriented to the expansion of services and improvement of quality. Therefore, the attraction of European patients (and leisure guests) and economically better off Ghanaian patients, as well as arrangements with companies became important.[27] High technical standards, the highest possible number of patients, as well as the running of outstations were seen as necessary for the economic survival of the institution.[28] The mission house opted to restrict the number of patients and the referral of patients to Kumasi or Accra in order to minimize expenditures. The amount of medical work had to be reduced in order to save time for the proper 'mission work'. This dispute finally led a leading physician to resign. But the conflict about finances and technical standards included other aspects: the autonomy of the Agogo medical doctors vis-à-vis the mission house, and their relationship with the

[22] DMR Archives Lausanne. 5,1. Elim Hospital, Budgets. 1905:21.
[23] DMR Archives Lausanne. Nouvelles de nos missions médicales, n°8, 1937, p.7.
[24] Union of South Africa, The Provision of an Organized National Health Service of the People of the Union of South Africa, 1942-1944. Report of the National Health Service Commission.
[25] This is also true for Elim Hospital.
[26] Inspektor an Stationskonferenz, May 1937.
[27] This refers particularly to the closeness of the administrators of Agogo Hospital to the Union Trading Company (UTC). It was that former Basel Mission Trading Company which, provided financial means, firstly for the building of Agogo Hospital, and then, for its staffing in order to maintain and improve the technical infrastructure. The relation with UTC was part of the conflict between the managers of the hospital and the staff (doctors). The financial dependency led to worries in Basel and Kumasi that the UTC was exercising too much influence on the hospital. See: 'Bellon an Hartenstein' (January 1931); 'Hartenstein an Bellon' (April 1931).
[28] See: 'Stationskonferenz', (May 1936); 'Stationskonferenz', (June 1937); 'Stationskonferenz Agogo', (July 1938).

missionaries on the ground; the role of the Union Trading Company (see below); and also the ideological closeness to German National Socialism by some of the (German) hospital staff. By the early 1950s, the colonial state in the Gold Coast had started financially to support mission health care activities. This led to a significant increase in the number of health institutions run by missions: these grew in the Gold Coast from three in 1951 to thirty in 1960. The same is also true for Tanganyika, but to a much smaller degree; here, the mission and its friends became more and more financially supportive and engaged up to the mid-1960s, when they handed over St. Francis Hospital to the local Roman Catholic Church.

We may conclude that all hospitals studied in this project were originally constructed and established with Swiss funds: the 'Société Immobilière' founded in Lausanne with the objective of funding the construction of Elim Hospital[29]; the Union Trading Company of Basel Mission (the former Mission Trading Company) financed the Agogo Hospital; and St. Francis Hospital was also set up with significant financial means from Switzerland. The missionary headquarters in Basel and Luzern might have extended this funding had these (Swiss) hospitals been more concerned with spiritual and evangelical tasks.

In the case of Agogo, the major financial contribution covered the wages of European staff, as well as investments in infrastructure and material. From the early 1960s, the mission was increasingly joined by other Swiss organisations in its funding efforts: church organisations, congregations, and private groups on the one hand, and the Service for Technical Cooperation of the Swiss Government on the other hand. The diversification of overseas donors continued to become an international operation, including church, private and government organisations mainly from Germany, the Netherlands, and to some extent from the USA. In South Africa, government contributed fulsomely to the CHF 180'000initially provided by the Société immobilière for the construction of Elim hospital.[30] Indeed, after the creation of the Société Immobilière, the Swiss Romande Missionary at first stopped its financial allocation. The headquarters in Lausanne recalled that the medical mission had to be self-funding; the headquarter's support would mainly focus on providing Swiss medical doctors and other health staff, not the costs of infrastructure and the running of the hospital. As a consequence, the Transvaal administration invested in the hospital and this gave it a growing say in the running of the institution. This would end with the takeover of Elim Hospital in 1976.

Some synthetizing conclusions of Section I:

- All three Swiss mission hospitals were established in the wake of war, turmoil and hostility. Post-conflict transformation, the restructuration of society and political governance provided new terms of reference for these missions, and the new 'rules of the game' in these British colonies meant an innovative challenge for them to sustain their role and to find their place. In this first period of hospital development these spiritual institutions have found their position by providing generally uncontested complementary work and services – nota bene in mostly remote, underserved rural areas – within the framework of given colonial (health) structures.
- The spread of the gospel was an important part of the 'calling for vocation', particularly in South Africa and Ghana. This strong 'sense of mission' was to a great extent represented by charismatic, pioneering individuals (South Africa) and by 'zealous' individuals who were embedded in missionary institutions (Ghana). Increasingly, medicine as well as

[29] Grandjean A, "La Société Immobilière. Ses premiers travaux, ses perspectives d'extensions", Bulletin de la Société Romande, Tome 13, 1905.

[30] At the First General Assembly of the Société Immobilière, on 3 February 1899, it was noted that the Société had gathered CHF 132'000. In 1905 a report of the Secretary of the Swiss Romande Mission mentioned that a total amount of CHF 180'000 has been provided for the building of the hospital.

education (including health education) became thus meaningful 'vehicles' and bearers of Christian values such as the grace of charity and the healing ministry in all three Swiss mission hospitals.

- Nevertheless, in the very beginning, medical work was not fully recognised as an integral part of a mission's tasks – and it took more (Ghana and Tanzania) or less time (South Africa) to persuade the missions' headquarters and their board members in Switzerland to acknowledge and appreciate 'medical mission' as a representation of spiritual-religious activities (which was far less the case in Germany and the Netherlands). Hospitals and doctors as spiritual representatives of an intrinsically secular institution had to navigate continuously and cautiously between the theological-religious requirements and norms of the mission and the worldly-profane characteristics of a professional health institution in faraway Africa. In fact, the 'career' of each of the three Swiss mission hospitals was constantly shaped by mediation between these two perceptions and attitudes.
- The significant process of 'secularization' of the three Swiss mission hospitals and its study have produced three different meanings, which depend on varying time, space, and context: the secularization of Elim Hospital was shaped by an increasing political influence and tight control of the South African government (particularly during apartheid) regarding important health policy and strategy decisions to be made in the hospital, through direct financial involvement and through integration of hospital services into public health structures. In Ghana and Tanzania the Agogo and St Francis hospitals had already experienced policy interventions in medical matters under the British colonial government, but in the Ghanaian case a major development was the hospital's integration into the independent church and, subsequently, step-by-step into the national health care system of the independent state. Similar changes occurred in St. Francis Hospital in Tanzania: integration into the Tanzanian local Roman Catholic structure and into the national health system of independent Tanzania. Secularization (of these three mission hospitals) in its wider sense means above all a gradual diminution and loss of authority of the mission in Switzerland. The government's strong arguments were as follows: national (health) needs have now highest priority; a national health policy requires a certain degree of systematization and coherence as to health care delivery; and hospitals have to improve their coverage and efficiency for the sake of the wider society.
- Already in their first years, the three Swiss mission hospitals (particularly Elim and Agogo Hospital) were pioneering and running a model of rural health care, which was directed towards community needs and lay persons' health concerns. This health policy orientation of Swiss mission hospitals led to a reconfiguration of the existing health landscape, namely imposing the new role of a hospital as an integral part of a hospital-based bigger health care network, which also included preventive and promotive health activities. Nevertheless, it is clear that the Swiss mission hospitals have to be considered as committed representatives of scientific biomedicine – and thus as not very concerned (or interested in) existing African, vernacular medical cultures.
- The funding of the Swiss mission hospitals – a fairly under-investigated field – during the period of their establishment happened almost exclusively through money transfers from the mission in Switzerland. This policy (of the headquarters) became gradually challenged (particularly for Elim and Agogo Hospital) by the missions' principles of maintaining self-sufficiency and self-reliability of all mission activities in Africa and Asia – including infrastructural developments and the running of the hospitals. Nonetheless, in the long run a certain tri-partite agreement was reached with regard to hospital running costs: the mission, the government and the users/patients were to cover these expenses. Yet, finances and funding were permanently considered as a terrain of debate and contestation: funding

being applied (or misused) as a powerful tool to direct and control the hospital's policy and related decisions; the threat (or danger) of phasing-out of payments from the missions in Switzerland after their hospitals were integrated into the national health care structures; and the introduction of new user fees and cost sharing models in mission/church hospitals.

Section II:

Characteristics of Health Care Concepts and Provision in Rural Settings

Introduction

This section compares the changing strategies and practices of health care delivery by the three hospitals and comments on their role within the national and local rural health care system.

While the importance of medical missions in Mother and Child Health services in Africa is a dynamic field of current research in colonial history – to which the case studies of this project contribute further empirical data – the project produces new perspectives on the general (or generally assumed) character of mission medicine: its 'curative bias'.[31] Our case studies confirm this characteristic of mission medicine for the period up to the 1970s, highlighting especially surgery (and the surgeons) as the model of a 'mission doctor', but also showing instances where the mission's activities went beyond curative, hospital-based medicine. Even more importantly, for the under-researched theme of changing medical paradigms in the 1960s and 1970s, the comparative approach yields detailed insights drawing on material from the study of the specific experiences in the field. When from the middle of the 20th century concepts of basic health care, health education and community-based health care became the core of national and international health strategies for so-called developing countries, the three case study institutions reveal different ways of encountering this development. When WHO's Primary Health Care concept (or, in the case of South Africa, the 'comprehensive health policy') became the guideline of the official health policies in the case study countries, all three institutions acquired a definite role in these health care systems. The comparison shows how the relationship to the state and other local and foreign organisations, developments at the organisational background of the hospitals, financial considerations, and not least the educational background and the professional networks of the senior hospital staff coined the strategic direction of the hospitals and their practical role for the implementation of changing health policies on the ground.

'The Poor and Needy': Target Groups, Access and Fees

The question of access to health care services, coverage and 'equity of delivery' is, until today, one of the major topics concerning health in Sub-Saharan Africa. It relates mainly to the availability of services and the barriers to accessing them. Many studies in medical history show the uneven distribution of biomedical facilities, professional staff and service delivery, mostly highlighting an urban bias. Commonly this inequality is led back to the 'legacy' of colonial health care systems concentrated on the administrative, political and economic centres, while it was primarily the mission medicine that was concerned with rural health. This fact is confirmed by our study, but with nuances in the cases of Gold Coast and Tanganyika, where the British colonial government was not absolutely passive concerning rural health care. In the Gold Coast, for instance, mission medicine was quasi absent until after World War II, an ambitious scheme for village dispensaries, ran by the 'native authorities' was set up by the government from the end of the 1920s (following the model of Sierra Leone). But the scheme fizzled out by the middle of the 1930s in the face of lack of

[31] See e.g.: Michael Worboys, "Colonial and imperial medicine," in *Medicine transformed: health, disease and society in Europe, 1800-1930*, ed. Deborah Brunton (Manchester University Press, 2004), 232-233; Michael Worboys, "The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940," *Osiris* 15, 2nd Series (2000): 210; David Hardiman, "Introduction," in *Healing bodies, saving souls: medical missions in Asia and Africa*, ed. David Hardiman (Amsterdam: Rodopi, 2006), 6; Walter Bruchhausen, *Medizin zwischen den Welten. Geschichte und Gegenwart des medizinischen Pluralismus im südöstlichen Tansania* (Göttingen: V&R unipress, 2006), 111. To some degree this debate is also a discourse from the 1970s when e.g. Akerele and others for the WHO, or Gish for Tanzania, made statements critical of hospital and mission politics.

resources in manpower and finances; priority was again directed to the maintenance of health care institutions in the urban centres.[32] In Tanganyika, in turn, the combination of government with mission services was characteristic for rural health before World War II. Where the mission offered good services, like in Ifakara, the government seemed only too willing to leave dispensary services and curative medicine in the hands of the Capuchin Mission, concentrating its limited resources on other issues (but also taking back and placing government medical officers at the mission hospital in Mahenge when a crisis arose in that institution). In South Africa, finally, government health care facilities were concentrated in urban centres up to the mid-1970s, and the monopoly of missionary medical activities in rural areas was obvious. Thus, especially in the Gold Coast and in South Africa, the mission medical facilities under review were constructed to fill gaps in the existing health care systems.[33] As all facilities offered their services to everyone, regardless of his or her religion, they were able to provide treatment to a part of the population with only limited access to biomedical health care.

Concerning the ability (and/or willingness) to pay health care services and the controversial question of user fees, the charitable claim to offer health care to everyone was confronted with the economic necessities, as all three institutions were obliged to cover a substantial part of their expenses with their income. In the case of Agogo, the hospital was meant to be self-supporting before it received government grant-in-aids in the 1950s, and throughout its history it had to generate between one and two thirds of its budget by its own. Elim and Ifakara Hospital were obliged to raise similar parts of their expenditure through fees. Accordingly, free treatment was not a characteristic of the mission institutions as examined in this study. Agogo Hospital did not deliver services for free for most of the time with some exceptions (i.e. certain services mainly in the area of Mother and Child Health were delivered free at certain times). In St. Francis Hospital, services were free after 1976, when the Tanzanian Government introduced free medical treatment. This led to an enormous growth of medical work. In the early 1990s user fees were re-introduced in order to steer the flows of patients. In South Africa, the generalization of subsidies for mission institutions (Financial Act 1935) and then the increase of the public funds to faith-based hospitals, particularly since the 1950s, led the state to decide that those hospitals should provide medical service free of charge. At the same time special services, such as surgery, were delivered as 'private practice' within the hospital. By the 1960s, consulting fees were reintroduced.[34] Thus, while the ideological foundation of the medical missions was the preoccupation with the 'poor and needy', financial pressure and lack of resources time and again led to the question to which extent the hospitals should provide attractive services for the 'rich and sick'. But even though patient fees were the rule for most of the time in the facilities under review, there had been in all cases a tradition of flexibility in charging fees from the very beginning. While the payment system was highly personalised in Ifakara (Tanzania), in Ghana the Basel Mission introduced a special fund for poor patients in 1959. Elim received a government grant for certified poor patients. Still, systematic efforts in order to improve access and usage of the facilities were only made in connection with initiatives towards Primary Health Care (see below).

[32] See: "DMS to Colonial Secretary," April 10, 1930, CSO11/1/677, PRAAD Accra; "DMS to Colonial Secretary," May 20, 1935, CSO11/1/679, PRAAD Accra; "Acting Colonial Secretary to CEP, CWP, CCP," August 23, 1935, CSO11/1/679, PRAAD Accra; "DMS to Colonial Secretary," April 13, 1939, CSO11/1/677, PRAAD Accra; "DMS to Colonial Secretary," May 30, 1939, CSO11/1/677, PRAAD Accra.

[33] For Agogo see e.g.: "District Commissioner Ashanti-Akim to Commissioner EPA," January 25, 1929, CSO11/14/19, PRAAD Accra; "Senior Medical Officer, Kumasi, to Chief Commissioner, Ashanti," March 21, 1929, CSO11/14/19, PRAAD Accra.

[34] Elim Hospital Archives. Cash Books, 1900-1964, Comptes privates du Dr Rosset.

'Mission Medicine': Curative, Specialised, Hospital-Based Medicine

All hospitals under review can be characterised as 'typical' missionary medical institutions focusing on hospital-based (or clinic-based), curative – mainly surgical – medicine until the early 1970s. At the same time, all cases provide examples of how the missions' activities already in the first half of the century went beyond the strictly curative field and beyond the hospital walls. In the case of South Africa, the Mission had established clinics and dispensaries since the 1920s and 1930s at Tlangelane, Shiluvane, and Masana. In 1941, the hospital board at Elim defined the extension of "health services for the natives in the district, by means of clinics and dispensaries" as a priority.[35] The dispensaries of Shiluvane and Masana eventually became hospitals. By the mid-1940s, the mission operated 53 health institutions in the Transvaal, including the three hospitals and several clinics. In Tanzania, the mission medical system was fully based on dispensaries run by missionary nuns who had undergone a full-scale nursing training in Switzerland. The dispensaries often offered a small number of beds for in-patient treatment. As soon as there were physicians, there was a call to have a hospital – but, if no longer at the heart of the system, the dispensary system was still just as important as the hospital sector. One of the tasks (with which the hospital doctors were rather overburdened at the beginning) was the supervision of the dispensaries. Also starting from Agogo Hospital, the physicians and other staff regularly visited a small number of clinics and dispensaries at other towns or villages. Yet, Agogo Hospital was until the 1960s a prime example of a mission hospital with its (surgeon) doctors as the essence of its medical endeavour. While the Capuchin Mission in Tanzania built itself such a flagship and centre for the medical work at Ifakara, the Basel Mission in Ghana started to extend its medical work in the 1950s, not necessarily beyond the hospital walls into the district, but rather beyond the district, especially into the north of the Gold Coast.

Regardless of the geographical extension and decentralisation of medical services, curative work remained paramount until the 1960s and in some instances into the 1970s, with surgery as the main occupation of the 'mission doctors'. Gradually, further specialisations e.g. in hernia surgery (Ifakara) or ophthalmology (Agogo, Elim) arose, largely because of the particular qualifications of certain physicians. At the same time, up to the 1950s, a certain amount of 'health education' took place in waiting rooms and wards, and missionary activities such as girls' education or women's work can be associated with aspects of health education as hygiene or nutrition, e.g. in the Gold Coast.

Primary Health Care Approaches

In all case studies, hospitals that can be characterised as strongholds of curative, highly technical medicine up to the 1950s, were integrated into public health policies in line with the governments' Primary Health Care (PHC) strategies by the end of the 1970s: St. Francis and Agogo were officially designated 'district hospitals', Elim Hospital had become a government hospital with its assigned place in South Africa's 'comprehensive health policy'. On first sight this suggests a long-term shift from hospital-based, high-standard, curative to community-based, basic, preventive health care in all three institutions. But the development that led to the integration into and adoption of PHC policies shows significant differences in all case studies. Neither was the outcome as similar as it might look.

In the context of all case studies, decentralised basic services and preventive medicine were a concern of the public health policies after World War II. In Tanganyika and the Gold Coast, preventive medicine was part of late colonial health care policies and found its expression mainly in disease eradication programmes, to some extent also in health education campaigns.

[35] Elim Archives. Elim Hospital Board, 1941, p.1.

By the 1960s, the independent states had made preventive medicine and a more even distribution of (basic) health care services major pillars in their development policies (even though many of the initiatives of this period got stuck with the economic problems of the 1970s). Both Ifakara and Agogo Hospital were still rooted in their curative conception and showed a certain degree of resistance to this development from the 1950s. But the process that led to their similar status by the end of the 1970s took different turns and was driven by different forces.

The hospital management at Agogo Hospital was rather reluctant to adopt the 'modern' health care strategies propagated by government, and explicitly associated with it.[36] But from the early 1960s, this hospital adapted more and more activities that were later subsumed under the concept of PHC, mainly in connection with paediatrics and Mother and Child Health. This process was propelled by the increasing collaboration with and dependency on the state, but also by a new generation of practitioners – at the hospital as well as in other health care facilities of the church – and their interest in current health strategies and involvement in 'progressive' scientific networks.[37] Nevertheless, curative medicine (as well as nurses' training) still remained at the centre of the hospital's activities, and its role was rather that of a referral hospital, while 'public health' was seen as a task of the government. In 1976 a 'rural health care programme' was introduced at Agogo Hospital, again propelled by changes of personnel.[38] Finally, when Ghana adopted PHC as a national policy in 1979, Ashanti-Akim became one of nine pilot districts for its implementation – with Agogo Hospital as the district hospital providing the head of the District Health Management Team.

In Tanzania, based on the Arusha Declaration of 1967, community involvement and self-help *(kujitegemea)* were part of the national ideology. But at St. Francis Hospital – with decision-makers showing more 'resistance' than at Agogo Hospital – these ideological developments in the political setting did not provoke any adjustments in practice until the late 1970s. When the hospital was designated a district hospital, the government built an atypical two-pronged system, where public health and PHC dimensions would remain in the government district office, while the hospital was to concentrate on curative services – a division that was never laid down in clear terms and which was, for a number of reasons, constantly renegotiated in rather controversial ways.[39] Only after the early 1980s did a slow generational change in the missionary doctors take these issues ever more serious, probably more so than the communities themselves. Doctors from the hospital were involved in 'research' in community health through their rather direct involvement with the Swiss Tropical Institute Field Laboratory (STIFL). During that time, the mid-1980s, the hospital started a Community Health Department, which was a small, albeit for donors a central, aspect of the hospital's work that coupled the hospitals traditions with new concepts of comprehensive health care or the policies of community participation, and the involvement of Swiss Development Cooperation which became one of the major funders of the hospital in this era.

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[36] E.g. Brack, "Jahresbericht 1950," March 28, 1951, PS1-B05-03-10198, Basel Mission; Hans Meister, "Jahresbericht 1958," 1959, PS1-B05-03-10198, Basel Mission; Hans Meister, "Jahresbericht 1960," 1961, PS1-B05-03-10198, Basel Mission.

[37] See e.g. Hans Meister, "Jahresbericht 1965," 1966, PS1-B05-03-10198, Basel Mission; Fritz Raaflaub, "Gespräch mit van der Mei, 10.3.1972," March 10, 1972, PS1-G05-03-1624, Basel Mission; Presbyterian Church of Ghana, "Report for 1970," 1971, 81; G.J. Oosterink, "Medical Development Plan: Bawku District," in *Triennial Consultation, Accra, August 24-26, 1971*, 1971, 62-77; Presbyterian Church of Ghana, "Report for 1972," 1973, 45-47.

[38] Presbyterian Church of Ghana, "Report for 1976," 1977, 23; Presbyterian Church of Ghana, "Report for 1978," 1979, 103; District Health Management Team, "Ashanti-Akim District Profile," December 1979, 45; *Agogo Hospital 1931-1981* (Agogo: Agogo Hospital, 1981), 30-33.

[39] Some of the conflicting elements were: competition for donor money, new concepts of mission medicine, the fact that the expertise was in the hospital. See also section 'health institutions' in Chapter III.

Elim Hospital, in contrast, presents itself as the most 'progressive' of the case study hospitals in terms of adoption of PHC strategies. In South Africa, even though the new Republic (1961) was expelled from the WHO in 1964, health decision-makers were aware about PHC strategies. Elim Hospital appeared at the cutting edge of practice in terms of PHC practices. The hospital benefitted from its European medical doctors, such as Peter Kok from the Netherlands who opened the service of Community Health in the course of the early 1970s and initiated community public health studies among primary school pupils. Further initiatives focusing on community health finally led to the creation of highly successful care groups in 1978 (Sutter and Maphorogo, 2003). The generation of missionary staff at Elim Hospital in the 1970-1980s expressed a kind of political engagement that broke with the central concerns of previous missionary workers. Accordingly, they designed the care groups as organizations of women aiming at fighting against health problems by employing basic health education within their communities. This health care strategy was a grass-root strategy disconnected from government policy. It would later exert an important influence on primary health care in South Africa.

The early receptiveness for PHC strategies within the management of Elim Hospital might explain the absence of conflicts about priority setting and fund allocation between PHC program elements on the one hand and high medical standards and specialization on the other hand (for which Elim Hospital was still renowned). In fact, in none of the hospitals, did the integration into the national PHC strategy mean a decisive shift away from highly technical, curative medicine. But at Ifakara, in contrast to Elim Hospital, the question of maintaining standards led to fierce conflicts between the medical staff, about the allocation of resources to specific sectors in the hospital and, not least, the need to find funding for the hospital in general. Here, turns in funding policies, e.g. the prioritization of PHC programs, fed back into these struggles. St. Francis Hospital (where the church and the public wished to keep up curative services of a high standard – services that tended to become ever more expensive with the advance of medical technology) created new services, like the community health department, which competed for the hospital's resources, while at the same time offering new funding opportunities. Also at Agogo, in the early 1970s, the question arose about why and how technical standards could be kept, or whether Agogo should "become a much more simple rural district hospital" with "better integration into the local community … as far as public health is concerned". The hospital management had made clear commitments to "high standards" and specialisation. An important argument for this position was that such standards were a condition for retaining the training of state-registered nurses at the hospital.[40] The Ecumenical Nurses Training College, in turn, fostered Agogo's important position within the Christian Hospital Organisation of Ghana.

Judgement and Use of Traditional Medicine

The study did not produce significant results on the role which traditional medical knowledge and practice played within the hospitals. The general rejection of traditional medicine and the absence of its application were mentioned in the sources, but they cannot be taken as full evidence of its insignificance for treatment and healing at the hospital: Patients as well as practitioners and healers have to be seen as part of a socio-cultural environment within medical pluralism, where traditional medical knowledge, local practice and non-Christian beliefs are omnipresent – and therefore one cannot assume that this medical culture has stopped at the hospital gate.

From the beginning of the early 1970s, the integration of trained Traditional Birth Attendants

[40] Hans Meister, "Missionary Medical Work," in *Triennial Consultation, Accra, August 24-26, 1971*, 1971, 54-55; Presbyterian Church of Ghana, "Report for 1974," 1975, 77-79; Presbyterian Church of Ghana, "Report for 1975," 1976, 97.

(TBAs; and to some extent other selected traditional health practitioners) into community-based services was introduced into Ghana's national health care system.[41] In Tanzania and South Africa, similar efforts followed in the 1970s. But none of our case study institutions was especially receptive towards such developments. E.g. Agogo Hospital does not seem to have adopted any activities in this respect before its designation as a district hospital in 1979.

Summary

Throughout the first half of the century, all three Swiss missions introduced – more or less independently from the state – curative medical services of comparatively high technical standards to people living in rural areas. Even though there were no systematic policies (yet) towards the improvement of access, this led to a punctual upgrading of availability and, to some extent, affordability of biomedical health care.

The case studies do not only confirm the curative bias that shaped the missionary medical facilities under review in the time up to the 1970s. They also show that it was the state that stressed public health efforts from the end of World War II – and the mission institutions were at the beginning rather followers (or even non-followers) than pioneers. The comparison of the three case studies highlights how the processes that led all hospitals to an official role in a national health care system geared to PHC is characterised by different accelerations and breaks. At Elim Hospital, a highly developed consciousness about the role of social medicine in combination with the eventual take-over of the hospital by the state led to the pioneering role played by the hospital in South Africa's 'comprehensive health policy'. At Agogo Hospital, a slower process was driven by outside pressure as well as by generational changes within the church and the hospital. In contrast to Elim, the case of Agogo shows a striking amount of resistance towards new paradigms in health strategies, assuming such developments as a threat to medical standards. The resistance was even more explicit and controversial at St. Francis Hospital. Although designated as a district hospital in 1976, it required pressure from Switzerland in the 1980s-90s for the hospital to place PHC at the centre of its activities. This occurred when donors threatened to re-channel funds from the hospital sector to district health work.

Finally, in the post-Alma-Ata era (i.e. after 1978) all three hospitals were officially assigned a central place in the structure of the local health care system according to the dominant paradigm of PHC. At the same time, all hospitals still claimed (and still claim today) a certain standard of quality of care and of specialisation – e.g. in training (Agogo, Ifakara), ophthalmology (Elim, Agogo) or medical research (Elim, Ifakara) – that exceeds that of an 'average' referral district hospital. In the face of a shift from more curative medicine inside the hospitals to a more 'comprehensive' approach, with a focus on basic and community-based health, the tenacity with which high medical standards and specialisations have been maintained at all three hospitals still needs to be examined.

Some synthetizing conclusions of Section II:

- In contrast to Agogo and St. Francis Hospital, Elim Hospital in the early 1970s was certainly a fine example representing a health institution which developed its own strategy when introducing and implementing comprehensive community-based, basic health services in rural areas. This active disconnection from (rather than resistance or refusal of) national health concepts sheds light on the scope of manoeuvre of each of the three mission hospitals regarding the development of a particular primary health care/public

[41] See e.g.: Patrick A. Twumasi and Dennis Michael Warren, "The Professionalisation of Indigenous Medicine: A Comparative Study of Ghana and Zambia," in *The Professionalization of African Medicine*, ed. Murray Last and G.L. Chavunduka (Manchester University Press ND, 1988), 117; Wilbur Hoff, *Traditional Practitioners as Primary Health Care Workers: a Study of Effectiveness of Four Training Projects in Ghana, Mexico, and Bangladesh* (WHO, Division of Strengthening of Health Services, 1995), http://apps.who.int/medicinedocs/en/d/Jh2941e/.

health strategy – and thus deciding whether 'the hospital without walls' – by the way a widespread initiative of the (Protestant) Christian Medical Council in Geneva in the early 1970s – would be implemented or the 'walls around the hospital' would just be elevated. Particularly Agogo and St. Francis Hospital have chosen to follow a pragmatic kind of 'double strategy': maintaining the hospital's high medical standards and at the same time fulfilling its role and function as 'ordinary' district hospitals in a wider network of primary health care.

- The post-World War II years until the early 1980s were to a great extent also conflictual times where again the three mission hospitals had to reconfigure and realign both their legitimation and their role under colonial governments and under new independent regimes. The mission hospitals were confronted with new diseases (e.g. diverse persisting tropical infectious diseases and with non-communicable illnesses) as well as different and changing health profiles (due to class and race and to migration and seasonality such as in Elim Hospital), with new political constraints and pressures (such as Apartheid in South Africa), with newly important political ideologies (such as African Socialism in independent Tanzania and partly in Ghana), with newly emerging health priorities and needs now formulated by national ministries of health (such as a nationwide coverage with vertical programmes of infectious diseases eradication in Tanzania), and finally the emphatic focus on WHO's Primary Health Care programmes (e.g. in Tanzania and Ghana). These important transformations did not leave the three hospitals untouched: the long-lasting discussions and debates, for instance, about 'free treatment vs. user fee', 'clinically oriented hospitals with high European medical standards vs. community-based preventive and promotive 'social medicine'', 'self-sufficient vs. profit-oriented hospitals' and finally 'spiritual-religiously conducted charitable medical services vs. secular-technical, highly professionalised treatment and diagnosis' are embedded in these mentioned transitions and dynamics. For example the discussion about the introduction of user fees in St. Francis Hospital (Tanzania) is intrinsically linked with the greater political environment in Tanzania, namely the Arusha Declaration (1967) of Julius Nyerere and his proclaimed 'Third Way of Socialism'. New actors as well as new ideologies, visions and concepts entered the (health care) arena, and they have had a powerful impact on the role, function and nature of the three mission hospitals – and in the process have marginalised the influence of the Swiss mission societies.
- One of these new secular dynamics of modernity arises through the internationalisation of medical cooperation that was implemented through attracting scientific medical research projects and receiving funds for a hospital now declared and assigned as a development project. This process certainly helped, in the cases of Elim and St. Francis Hospital, to maintain their high medical standards and skills – but it also led quite soon to an intentional bypassing of health policies (set up by government) in pursuit of non-profit, basic, safe and effective medical activities outside the hospitals.
- It is nonetheless a surprising fact that the management of all three mission hospitals did not (or did not want to) recognize local traditional medicine as part of their medical reality. This stance clearly shows that the mix of Christian 'sense of mission' and biomedical hegemony has led to a very biased and distorted image of 'local culture' of where the hospitals seem to be part. Important health-related practices such as divination and healing, and the knowledge of local herbalists were not perceived – or were refused. The health strategies to which lay people turned is an as yet under-investigated field in medical history. Nor do we have much evidence about the opinions and attitudes of Christian, local hospital staff (e.g. nurses, secretaries, cooks, drivers, or guards) regarding traditional medicine and its relationship to 'modern' hospital biomedicine.

Section III:

Identification of Actors in Health Systems
Introduction

This section gives answers, based on comparative discussion, to the research question and topic of 'identification of actors in health systems and their perspectives'. The idea is to look at motivations, but even more at roles, played within health service delivery. We concentrated on practices rather than on roles as they were conceptualised or assigned by a system.[42]

During our research, we came up with a number of actor groups. These are (in an alphabetical order) as follows: 1) Africans, (non-)users of services, translators; 2) churches and missions, donors and funders; 3) health care delivery institutions; 4) the health professions, professional bodies, training and recruiting agencies; 5) individuals, charismatic leaders; 6) pathologies, and equipment and infrastructure; 7) patients; 8) politicians; 9) researchers, experts, scientific institutions and international organisations; 10) the state.

Due to limited space we cannot discuss all ten actors in detail. Instead we focus on a selection of six categories, which is based on the quantity of research findings generated through comparison and on the centrality that an actor-category has for a historical understanding of rural health care.

Africans, (Non-)Users and Patients, Translators

In rural areas, missionary medical work relied heavily on indigenous Africans. This first category is consciously put at the beginning aiming to emphasise the significance of their role in the care and cure giving within the field of missionary medicine. Secondly, Africans were major drivers of health development. It was indeed the way Africans used the institutions as medical institutions, but also as sources of income, status and knowledge, which shaped them.[43] While there were a number of African workers in the hospitals and health institutions under review, in the early stages almost all Africans entered the hospitals almost exclusively as patients. In order not to be blindfolded by a strictly medical perspective (where Africans would be patients or medical workers only), we introduced the idea of ‚*users*'. There is for example the substantial role of family members who have done most of the cooking and a lot of the care functions in St. Francis or Agogo Hospital until today. Nursing in the stricter sense was, especially in the case of Elim Hospital, confined as strictly as possible to health professionals.[44] In all hospitals family members, in order to contribute to the cost of treatment, or to generate a small extra income, could be enlisted in manual and supportive work.[45] Not least, the hospital's infrastructure and material basis, like transport or banking services, were offered as services to the public or used by the staff and others for other undertakings – not always following medical rationalities or the supposedly correct sense of the organisation (le-

[42] For more on the methods of this work, see the special section concerned with methodology, which forms part of this report to SNIS.

[43] The history of 'medicalization' is driven by both supply and demand– a notion that has been taken up in discussion of the 'medical market'. We would add that in the case of rural hospitals medicalization has to be read even beyond the medical in so far as medical institutions were partly driven by demand for 'development'.

[44] Mavila Kwaiman: Interview, Elim Waterval, 9 December 2008; Charles Interview, Louis Trichardt, 4 October 2010.

[45] Interview with Sr. Josephata, Dar es Salaam, April 2009; interviews conducted in Elim Hospital show that the hospital saw the inclusion of temporary workers as a sort of social work. At two points in time the camp for family members at St. Francis Hospital in Ifakara saw major changes: At first, it was moved from the immediate hospital ground to a location opposite the road leading to the main entrance when an extension of the Rural Aid Centre was undertaken. Karl Schöpf. *Letter to E. Maranta. Ifakara 12.06.1961*. PAL: Sch 1061.6.; Later, in the 1980s, money from a substantial donation to Sr. M.P. was used to build a good camp with kitchens and accommodation (Interview Sr. M.P., Baldegg, January 2010).

gal, bureaucratic, ethical, official).[46] All three hospitals were major economic players, at times they were as in Ifakara the biggest builder, or the largest housing entrepreneur, or in the case of Agogo Hospital the biggest single employer, and as such were used to complement livelihood strategies of Africans.[47] The very lively market and concourse of taxis and buses at the gates of Elim hospital attest to the important role played by this institution in the local economy and its transport infrastructure. In all three cases, people have used hospitals as discursive centers where they can negotiate access to development and welfare institutions and to local and transnational networks. Such roles were often taken by what is termed 'the community' (a term in need of thorough historical deconstruction).

Thirdly, with all its associated problems, such a broad categorisation also allows us to recognize the role Africans played in translating, transferring and transforming missionary medicine.[48] Not only medical staff, but also ordinary Africans played a crucial role here. In Elim Hospital, the mission sponsored activities of the Blue Cross Movement for abstinence, a topic that was also pertinent in the Capuchin mission in Tanzania. Within the Capuchin mission community lay organisations were also active in health matters in general: In the 1950s the Capuchin parish priest built a lay movement, the *Legio Mariae* in Ulanga. The 'Missionsbote der Schweizer Kapuziner' reported on these activities: "The main activity was in pastoral care [original version: 'Seelsorge']: Two members would together visit the sick, teach to heathens when they were dying and also baptize them ... Since they understood the mentality of their tribesmen better [than the Swiss missionaries] and were able to chat for many hours with them, they often were more successful than a priest and nicely prepared the souls for the comfort [original version: 'Zuspruch'] by the priest."[49] This quotation is a telling example of the importance and closeness of healing within pastoral care. In Tanzania, where maternity work, even in the bush, was a fundamental part of the mission's health activities, Africans were also drawn into medical work with every birth attended by a missionary nun: here often large groups of women were involved, negotiating, translating and extending birth attending techniques and concepts along the way.[50]

Churches and Missions, Donors and Funders

Missions and churches have a range of goals, and of course not just medical ones, and act in many directions. In fact, our study has developed only an ephemeral understanding of the spiritual motive of the church in healing. Since the medical and not the mission history is at the centre of this chapter on actors, the spiritual will be discussed under the following section on health institutions, while here the church as a worldly organisation is at the centre of our discussion, but not Christianity in its spiritual dimension linking humans with the eternal.

One direction to focus on is how mission medical work was thought to strengthen the missionary enterprise (see above). In the 1960s, this motivation was transferred to the local

[46] There is like a tradition that any missionary institution is part of the whole mission enterprise and extends its services outside the immediate institutional purpose. This tradition has lived on into the era when health institutions are often conceptualized as purely specialized elements in a system where a clear-cut division of labor exists.

[47] Not only the hospitals are impressive buildings, the housing for staff was generally a core of new villages. In Ifakara, the leprosy care centre ‚Nazareti' built, over the years, almost 100 houses in the Kilombero Valley. Interview Sr. M.P., Baldegg, January 2010; Documentation on ‚Leprastation Nazareti' in Institutsarchiv Baldegg.

[48] This is not a new finding of our study, but we did discuss these issues at the very start of this project with Walima Kalusa in a workshop in Basel (*Transfer and Translation in Medicine*, Workshop held at the University of Basel, 2007). See also his article: Kalusa, "Language, Medical Auxiliaries, and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia." *Journal of Eastern African Studies* 1 (2007). See also the classic study by Nancy Rose Hunt, *A Colonial Lexicon of Birth, Ritual, Medicalization, and Mobility in the Congo* (Durham, 1999).

[49] P.K.L., „Die Legio Mariae in unserer Mission," *Missionsbote der Schweizer Kapuziner in Afrika* 30 (1950), p.84. Translated from German.

[50] The best account of the complex negotiations when attending a 'birth in the bush' in the Ulanga Region can be found in Louise Jilek-Aall, *Call Mama Doctor. African Notes of a Young Woman Doctor* (Seattle, 1979), pp.101-112.

church (Diocese of Mahenge; Presbyterian Church of Ghana) in the case of Tanzania and Ghana. In these countries the hospitals remained church-owned and users still see them as institutions under religious control today. In these cases even government-seconded staff were assumed to be working in a church institution, while some of the religious staff, even religious sisters, were being paid from the government payroll. In the case of Elim Hospital, things developed differently: here, as seen above (in the introductory part), the integration into the national health system meant literally secularization: the Tsonga Presbyterian Church never came to profit from its missionary precursors' investments in the medical sphere – and never claimed it. Here former mission employees were considered as civil servants to be placed in any health institution by the government. The post-missionary churches in Ghana and Tanzania kept medical mission work because it strengthened the position of the church in the new political arena of the national welfare state and in the changing world of donors[51]. After Elim Hospital was taken over by the state, churches and missions in Switzerland continued to serve as donors supporting the hospital.[52]

For the standing in the community, the national and regional status of the institution was important; but also the fact that, for example, the St. Francis Hospital had, in 1969, 19 trained African staff and 75 'subordinated' staff.[53] Later the hospital became an even more important factor in reinforcing the role of the church as a big and important institution in society: Agogo Hospital employed a total staff of around 60 people in 1960 and of more than 300 in 1972. And in mid-1990s Tanzania, St. Francis Hospital, with a staff of 345, was among the largest employers in the whole region of Kilombero and Ulanga.[54] By that time, however, when government contributions were delayed, paying the staff on time was a huge problem for the diocese and its inability to assure its responsibilities in this respect was responsible for a lot of bad feelings towards the church.[55] Even if 350 families depended on the church hospital for their income, the number of patients treated was even more impressive. In 1966 more than 4'000 patients were admitted into the hospital in Ifakara, and in the mid-1980s this number reached almost at 10'000.[56]

If we see mission societies, as Paul Jenkins suggests, as *organisations or movements for idealistic activities*,[57] one should look at the way they picked up and expressed the motivations of the members of such movements. Here, in the organisational development of both the church and the medical institutions needed to negotiate changing regimes of donorship, philanthropy and solidarity, we see a lot of adjustments, but not all of them having been reached without conflict. On the contrary: conflicts sprang up inside the church as well as within the medical institutions. In the Tanzanian case, since the 1960s and into the 1980s, a new generation of missionaries challenged the ways of the older generation. It is said that part of these challenges came from people in central positions of brokerage between the mission, the new development cooperation sector and the public – people who were able to 'wed' institutions of the church with new development partners and funders.[58]

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[51] DEH. *Antrag Nr 99/1995 Ifakara Spital Phase 2 (7/95-6/98). Bern 02.05.1995*. BAR: E2026(A) 2005/9 t.311 Tansania 22 Bd 2 SFH.

[52] Elim Hospital or its specific programme such Elim care groups received donations from Switzerland in the Bantustan era. In 1994, the *Département Missionaire* continued its support by providing a mini-bus.

[53] St. Francis Hospital Ifakara and Sr. Sara. *Annual Report 1968 for St. Francis Hospital Ifakara*. PADSM: Box 155 Ifakara SFH 2.

[54] SFDDH, Thomas Pauli, and Ryszard Jankiewicz. *Letter to MoH. Ifakara, 27.11.1993 re: Staff situation at SFH (Quantity of employees)*. BAR: E2026(A) 2005/9 t.311 Tansania 22 Bd 2 SFH.

[55] Embassy of Switzerland in Tanzania, SDC Tanzania, and Gerhard Siegfried. *Letter to Principal Secretary of Health, MoH Tanzania. DSM 13.01.1995, Re: SDC support to SFDDH...* BAR: E2026(A) 2005/9 t.311 Tansania 22 Bd 2 SFH.

[56] St. Francis Hospital annual reports in PADSM.

[57] HHSA Advisory Board Meeting, 12 October 2010.

[58] E.g. Walbert Bühlmann, *Die Überraschungen meines Lebens* (Graz [etc.], 1994).

For – and as much as through – medical work the church organisations studied in Ghana and Tanzania were crucial actors in these fields of global solidarity and in effectively linking remote rural areas to global chains of charity. It was not only the field of activities, medicine, but also the people involved in this, as missionaries or expatriate volunteers, who made these ties work. Interestingly, in Elim Hospital, even if the Tsonga Presbyterian Church was not involved in the hospital, the presence of medical staff with links to the former mission society kept networks of solidarity active. Such networks helped the hospitals to continue appointing European staff until the retirement of the last Swiss missionaries in the mid-1980.

While such adjustments went on, one can make an argument that the presence of the missionary institutions not only channelled government grants but served as a catalyst for above-average government engagement, that it did in fact play the role of an advocate for community concerns. Elim Hospital was successful in pushing the government to consider local people's concerns by investing in the field of rural health care. In Tanzania, with the designation of St. Francis Hospital as a district hospital for Kilombero District in 1976, the government was ready to carry recurrent costs of a hospital that was more than twice the size of an average district hospital in Tanzania. Investments in the field of research later helped to bring services and treatments to Ifakara and Kilombero that were not seen in other peripheral areas of the country. However, when looking at the history of neighbouring district of Kilombero, in the District of Ulanga, where the Swiss Capuchin Mission probably had been an almost singular moderator of modernising development, after Kilombero and Ifakara was detached in the mid-1970s, there was hardly any additional engagement of government triggered by the presence of the church until the late 1990s, when it was clear that the 'mission' had left and only the local diocese was in place. On the contrary: the Mahenge Government Hospital, for example, seems to have been pushed to the periphery due to the presence of St. Francis Hospital in Ifakara (roughly half a day away from Mahenge). In the case of both Agogo and Elim, the presence of the hospital triggered investments of local (district, regional) governments into infrastructure such as roads or electricity.

Health Care Delivery Institutions: the Spiritual and the Secular and as Focal Points of Power

Regarding the hospital as a spiritual and religious undertaking, a range of religious elements came together in these health institutions: the religious motivation of health workers was mediated by the doctrines of the institutions and shaped into spiritual means of healing and coping with illness, and vice versa. The spiritual dimension in these three mission hospitals still took different historical shapes, however.

Elim Hospital is a good example of an early medical missionary institution with a 'true' missionary programme: church services were held on the hospital grounds and every operation was started with a prayer. In Agogo Hospital, such a spiritual priority was a result of a new drive that came with the re-opening of the hospital after World War II when the hospital management's attitude toward medical mission changed. The new generation of physicians in Agogo fully committed themselves to the task of evangelisation. More weight was put on the (literal) spreading of the 'Word of God' and on proselytising in the 1950s. Daily services for the patients and bible readings to the out-patients before the consultation hours were introduced. Within the hospital the stress on Christian community was expressed in rituals such as devotions, services, Lord's Supper, the celebration of Christian holidays, joint bible study, and the formation of a Christian 'staff association'.[59] The proselytising function of the hospi-

[59] See e.g.: Brack, "Jahresbericht 1950," March 28, 1951, PS1-B05-03-10198, Basel Mission; Gertrud Meister, "Rundbrief," August 5, 1952, PS1-B05-03-10198, Basel Mission; Hans Meister, "Jahresbericht 1952," February 17, 1953, PS1-B05-03-10198, Basel Mission; Owusu Manteaw, "Pastoral Report, Basel Mission Hospital 1956," 1957, PS1-B05-03-10198, Ba-

tal had consequences for the medical practice as, for instance, a focus on the treatment of tuberculosis meant that most patients would spend long periods in the hospital.[60] From the end of the 1950s the directly proselytising function of the hospital started to lose its importance (at least in the expressions of the hospital's administration working in a changing political and social environment). The Christian spirit of the hospital was to be manifested through an exemplary role in the daily work: the care and love for the sick was understood as the main expression of Christianity.[61] Now the training of (Christian) nursing staff became central as a means of spreading Christian values rather than beliefs. St. Francis Hospital had its place in a different religious environment: Ifakara was seen, by the mission, as a difficult place for Christianity because of the strength of Islam in the region. If the hospital was a spiritual institution, this is felt less in the sources, where the religious purpose is much less explicit, than in the other case studies. It is difficult to judge if this absence reflects a silent practice of religiosity or a secularized, or at least ecumenical, reality. Certainly from the very beginning it was a central aim of the medical institution within the Catholic Church to reduce poverty and sickness in order to offer a fertile ground from which Christian spirituality and practice could grow. The strategy of the St. Francis Hospital in Ifakara therefore was to make sure that Christianity had a firm hold in the most important economic hub of the region. To reach these aims a silent symbolism of the work accomplished was planned to testify to the dedication. What we learn from this argument on the spiritual role of the health institutions is that such an institution is an actor not only in the medical field.

Our second main argument in this section is that our actor categories (like mission, state, health professionals) are better understood if brought into a joint field of analysis by looking at their interrelations, rather than as categories apart. These interrelations of many actors become manifest in the practices inside the health institution, practices which at the same time turn the institution into a node of power, an agent in itself.

At the top of the institution, the interrelations became effective in the management boards, and in all the case studies, the development of these boards is a good example for some of these interconnections. Hospital boards took or oversaw important decisions in the hospital which were also setting the pace for health delivery in a regional or district perspective. At the beginning Elim Hospital had no management board but was dependent on the decision taken in the missionary conference in the Transvaal as well as the 'Comitée Médicale' in Neuchâtel. Clearly non-medical missionary staff was in the majority in this board. Since the very beginning of the hospital, Elim Hospital had a *Commission de l'Hôpital* managed by the hospital director. In the early 1940s, local representatives entered the Elim Hospital board of management for the first time, which now consisted of members of the Swiss mission, the superintendent of Elim Hospital, a delegate of the Transvaal local administrator, and representatives of white farmers.[62] But it was only in 1976 that the government decision to take over all missionary hospitals became effective at Elim Hospital.[63] After that, the management board consisted of the local administrator, the superintendent of the hospital, and community members. This became a typical example of a hospital within the national health system. Even though medical doctors and the superintendent were Swiss or of Swiss descent, the mission had now

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sel Mission; Presbyterian Church of Ghana, "Report for 1959," 1960, 14.Brack, "Jahresbericht 1950"; Gertrud Meister, "Rundbrief," August 5, 1952, PS1-B05-03-10198, Basel Mission; Hans Meister, "Jahresbericht 1952," February 17, 1953, PS1-B05-03-10198, Basel Mission; Owusu Manteaw, "Pastoral Report, Basel Mission Hospital 1956," 1957, PS1-B05-03-10198, Basel Mission; Presbyterian Church of Ghana, "Report for 1959," 1960, 14.

[60] Hans Meister, "Spital Agogo. Erste Eindrücke, Gedanken und Vorschläge," April 22, 1952, PS1-B05-03-10198, Basel Mission.

[61] See e.g.: Hans Meister, "Jahresbericht 1955," 1956, PS1-B05-03-10198, Basel Mission; Presbyterian Church of Ghana, "Report for 1958," 1959, 13-14.

[62] Elim Hospital Archives. Elim Hospital Board, Minutes of the meeting on September 7th, 1945.

[63] Gazankulu Legislative Assembly, Debates, Volume 10, Special session 1 September 1976, p.501.

officially nothing to do with the management of the hospital. At Agogo Hospital, before World War II, the "Stationskonferenz" was more or less exclusively in the hands of the (European) hospital staff – with at times only three present members. Accordingly, it was this board that represented the medical staff concerns towards the mission leadership in Kumasi and Basel. After World War II, the mission and later the church interests were more directly represented in the management board of the hospital, from the late 1950s by the moderator of the church at the national level as well as by the pastor of Agogo at the local level, together with, at that time, the European staff of the hospital. A senior staff meeting gave, from the early 1950s, a certain representation to senior African employees (generally qualified nurses with some working experience) with a status subordinate to the management board. The state was only represented on the management board from 1965 in the person of the District Commissioner – on the latter's own query, and after the board's agreement and the superintendent's formal invitation.[64] From this time the board gathered church, doctors and government to work together for the benefit of hospital and regional health care delivery.

The Board of Governors at St. Francis Hospital was originally formed in the 1966 as a reaction to the new structure of the Catholic Church in the former Archdiocese of Dar es Salaam, when Mahenge became an autonomous diocese. This split from Dar es Salaam had weakened the hospital as it removed the Bishop from the medical administration in Dar es Salaam and Morogoro.[65] However, by now Ifakara had become the flagship of the (former) mission church and it was visited by President Julius Nyerere on a number of occasions. Initiated by Swiss scientists, a field laboratory and a training school for medical staff was developed at this time at the hospital, whose top level management also came to sit on the hospital board[66]. When the hospital was integrated into the national health structure in 1976, the board was reformed to include more powerfully the members from the government side. And later, in the early 1990s Swiss Development Cooperation was included to represent itself as a major donor. Only in 1995 was there a discussion to include a 'community' representative in the board.[67] At that time, at Agogo, the newly formed Area Board had been introduced as the decision-making body of the Presbyterian Health Services Agogo (later Ashanti Akim), of which the hospital was part. Apart from the hospital management and staff, as well as the Presbyterian Church of Ghana, the Agogo Traditional Council, the Regional Health Services, the Ebenezer Presbyterian Church of Agogo and the Christian Hospital Association of Ghana (CHAG) were represented on this body.[68]

We learn from this short history of the management boards that the hospital was a node, an intersection where powerful interests, ranging from the medical to the owner and the donor side, were accommodated. This also brought the power of these interests to bear on the hospitals:

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[64] Meister, "Jahresbericht 1952"; Presbyterian Church of Ghana, "Report for 1958," 14; "District Commissioner to the Secretary to the Regional Commissioner," May 3, 1965, ARG2/13/1/3, PRAAD Kumasi; "Secretary, Medical Work, PCG to Secretary to the Regional Commissioner," September 16, 1965, ARG2/13/1/3, PRAAD Kumasi; "Medical Superintendent, Agogo Hospital, to Secretary to the Regional Commissioner," November 12, 1965, ARG2/13/1/3, PRAAD Kumasi.

[65] The files of the Ministry of Health in Dar es Salaam show that in most instances important communications between the church and the state did in fact go through the hands of the Bishop himself, he even visited the Director of Medical Services in his office (or vice versa) if crucial things had to be discussed: for example TNA 450 HE/178/16 or TNA sec files 26367 Note also that the Bishop in Dar es Salaam was also a central figure in the Catholic Church of Tanganyika – rather unlike the head of the Diocese of Mahenge, as far as we know.

[66] In the board were represented, apart from church and mission, the Medical Faculty of the University of Basel and the Basel Stiftung für Hilfe an Entwicklungsländer (BSFEL), and later the Swiss Tropical Institute Field Laboratory, St. Francis Hospital. *Board of Governors - SFH: Constitution [agreed on first meeting held 22.12.1966]*. ASTIBS: 6/2/6 "St. Francis Hospital". The two seats formally assigned to the government on the board were never taken during meetings; they did however reflect the necessity for the board to listen to government positions even if they were stated outside formal board meetings.

[67] Markus Frei. *SFDDH integrated health care project. Minutes: Projektdurchführungsdiskussion [Bern 09.08.1994, notes from 04.10.1994]*. BAR: E2026(A) 2005/9 t.311 Tansania 22 Bd 1 SFH.

[68] The introduction of the area boards was part of an organizational reform within the Presbyterian Health Services in 1991.

they had quick access to donors in times of need[69], and they were seen as the centres from which new health activities would naturally start and diffuse.[70]

The management boards are a case in point of how hospitals structured the perspective on health care delivery, and subsequently the activities in this field, by the fact that they were centrally located. Because hospitals remained the logistical and financial centres, as well as the loci of knowledge and status, in the struggles on allocation of resources, their positions remained largely unchallenged by health centres and dispensaries. One example for this is the financing of peripheral activates by international donors, who often were administered and managed through hospitals. Only slowly did district health officers and rural/community health practitioners at the hospitals merge into denser organisational connections,[71] and donors re-channelled their funds into District Health Offices instead of out-reach activities by the hospital.[72] At Elim Hospital the story of the care groups is another example of the hospital as a pace setter for health care delivery on a regional scale: what started out as a research undertaking by the hospital on trachoma (an eye disease often met but which could only be treated in a hospital operation theatre) developed gradually into grassroots groups at village level. The programme however remained managed and financed through a special department on the hospital grounds and the responsible people were closely tied to the overall management structure of the hospital. Indeed the superintendent was very supportive vis-à-vis medical doctors of both the ophthalmic service and the public health department working for the care groups. The hospital provided nurses or assistants who worked as Elim care group motivators.

Having said this, we conclude that it was the 'hospital community' rather than the 'village community' which established the needs to be addressed and the tools and interventions to be used. Our argument is that the health institutions were mirrored in the communities they catered for, not vice versa. The hospital was linked to expert knowledge, which turned undiagnosed fevers into 'fevers of unknown origin' rather than accepting the community explanations in the concept of, for instance, *degedege*.[73] Not least, these hospitals in general developed interesting, sometimes conflicting notions of the community. Historically the hospitals had roots in the idea of helping to secure the survival and growth of the Christian communities consisting of missionaries and the first Christian structures: In Tanzania, the first medical

[69] St. Francis Hospital was able to free itself from the financially critical position after the designation in 1976 thanks to the strong lobbying power it had through the entangled interests included in the board. See for example *Protokoll der 5. Jahresversammlung von MMS vom 30.04.1977 in Basel*. AMMS: MMS Protokolle Mitgliederversammlung. And documentation accessed at Privat Archiv E.Widmer, Thalwil.

[70] In the early 1980s, it seemed only natural that new research activities included St. Francis Hospital. Marcel Tanner. *Outline of a programme on applied research at the STIFL; a Memorandum [Ifakara 20.02.1981, english translation]*. BAR: E2200.83(B) 1999/351 771.22.8 u'ch.

[71] In the Ghana case study, a physician at Agogo Hospital became the first head of the local District Health Management Team with the headquarter still at the District Capital, Konongo.

[72] In Kilombero, STIFL as a new player in international health started PHC projects that step by step helped to rechannel funds from the hospital into the coffers of the District: see for example: Kilombero District Health Office and Kilombero Health Research Programme (STIFL Ifakara). *Collaborative Primary Health Care Project: Development and Implementation in the Kilombero District*. IHI: folder PHC, *SDC/Högger, Kücholl, Tarimo: Final report of the External Evaluation of the Kilombero Health Research and Support Project, Bern, June 1993*. ASML: R3T6O2quer Evaluationen 77/87/93 DEZA Gesundheitsprogramm Tanzania, Swiss Tropical Institute Field Laboratory STIFL, "Annual Report of the Swiss Tropical Field Laboratory Ifakara/Tanzania. January-December 1987," (Ifakara, 1987).

[73] Swiss Tropical Institute Field Laboratory STIFL. *Research Programme Nr 2: Preliminary Investigations on Malaria Resistance and Fever of Unexplained Origin (FUO) at SFH*. BAR: E2200.83(B) 1999/351 771.22.8 u'ch.; for a medical anthropology study on fever concepts in Ifakara, including the concept of 'degedege' see Susanne Hausmann Muela, "Community understanding of malaria, and treatment-seeking behaviour, in a holoendemic area of southeastern Tanzania" (Universität Basel, 2000). On these issues also Stacey A. Langwick, "Devils, Parasites, and Fierce Needles: Healing and the Politics of Translation in Southern Tanzania," *Science Technology Human Values* 32 (January 1, 2007).

services by doctors took their roots in catering for the mission boarding schools.[74] In the case of Agogo Hospital one can see how, at the introduction of PHC, the church's view on the community kept focussing more on education and morality whereas the hospital representatives perceived 'community,' and its role in health and development, more from a 'developmentalist,' and to some extent emancipationary, perspective. For example the District Health Management Team, headed by an Agogo doctor, propagated in its first district profile 'self-help', and the secretary of the church's Medical Committee, explaining the new strategy to the church members wanted to make the communities 'feel responsible' and teach 'individuals how to live healthily'.[75]

Health Professions, Professional Bodies, Training and Recruiting Agencies

We have also looked at professionals in health care systems from a perspective of professions and professionalization.[76] This research has shown that missionary medical doctors and other health professionals were very active and engaged within their profession. They have struggled for the shaping of their own professions, and they have been working towards the outside of their profession for influence and status in the larger politics of health care institutions.

One of the specific experiences of mission medical organisations is the history of those mission trained staff, whose careers later were blocked by their lack of qualification papers. From this example we learn that there was an era ending roughly in the 1970s when such African staffs, drawn exclusively from the mission church communities, was fundamental to mission medical work. It was central to producing a modernised Christian elite and it was the pillar on which the medical institution as an (African) missionary organisation was built. But the historical trend ran against this organising principle and this segment of staff.[77] The experiences of these health professionals who were more attached to the church professional service than to the health sector are telling on the pre-eminence of secularized qualification which came to play in the professional careers, even inside the church health service. While the staff at St. Francis Hospital mostly had a mission school background in the 1960s, by the late 1980s the crucial element in professional careers was no longer a mission school background but access to up-graded training. From those of the early days who were left behind, everyone experienced the strategic advantage of training for furthering personal careers, while such professional strategies also put health delivery under strain: the better trained the staff was and the stronger the competition amongst staff grew, the more they were absent in courses and preoccupied by struggling to get the coveted places in these courses. Looking at careers of health professionals, one may say that 'manpower' was a much misunderstood aspect of health planning, not least because normative concepts and ideologies of total engagement for the nation and the sick (as they were captured in hospital principles and mottos) most frequently collided with real life.[78]

A central example for this statement are the debates that addressed issues of health care ethos: The nursing profession grew out of an ethos of Christian charity marked by total commitment, compassion and asceticism, and mission institutions kept this ethos as a self-defining principle. This often collided with the modern professional ethos, which was, to make the contrast

[74] An interesting example are the first missionary doctors at Mahenge, for example Dr Gabathuler. They were pressing for a hospital, but were left to care for the school children for so long that it led to conflicts with the mission. PAL Sch 1061.5 Gabathuler. Alois W. Gabathuler, „Dr. Gabathuler berichtet aus dem katholischen Vikariat Dar-es-Salaam in einem Brief vom 29. Januar 1939," *Katholische Missionsärztliche Fürsorge*, Jahresbericht 1939 (1939).

[75] See: Presbyterian Church of Ghana, "Report for 1979," 1980, 72. And: District Health Management Team, "Ashanti-Akim District Profile," December 1979, 1.

[76] See the discussion of the concept by Iliffe. John Iliffe, *East African Doctors: a History of the Modern Profession* (Cambridge, 1998), pp.3-5.

[77] Such stories were collected in interviews, e.g. in Ifakara in January to April 2009 and in May 2010.

[78] For example in Agogo: „Heal the sick, and tell them, 'The Kingdom of God is near you.'"

more evident, centred on technical knowledge, educational qualification and workers' entitlements.[79] Nevertheless, the problems went further, when specific professions based on 'development' were created, and despite the ideals invoked, suffered from a shortage of trained staff and low wages. It could mean that going up the ladder of 'developmental' professions could mean to go down on the medical profession's status ladder. Or that when finally the lack of so called A-nurses, the best trained nurses, was repaired, a new gap had been opened in the ranks of the B-nurses, those who were actually performing much of the actual nursing.[80]

Training institutions were closely linked with these issues and their output defined health professionals. In all three case studies, training institutions played an important role: In the northern Transvaal the Swiss Mission Bible School of Valdezia, Elim and Shiluvane (1890s) led to the creation of Lemana College (1906). It became later a kind of laboratory of local auxiliaries for both evangelical and medical work. Most black nurses were trained in Swiss missionary institutions. Elim Hospital started a nursing training programme in 1932.[81] In the late 1940s, the training of nurses at Elim Hospital was assessed by the South African Nursing Council, and the trainee could now graduate for an auxiliary certificate – not only for a hospital certificate which had previously limited them to work only at Elim Hospital. At Agogo Hospital in Ghana, female and male staff was also provided with in-service training from the 1930s, although they did not receive any formal education. This changed after World War II: from 1950 Agogo Hospital formally trained nurses, and from 1956 it was acknowledged as a training institution. By 1969, more than 202 nurses trained in Agogo had been registered as Qualified Registered Nurses.[82] Afterwards, enrolled nurses (and from 1972 higher qualified State Registered Nurses) were trained for not only the hospital itself, but also for the various health care institutions of the Church. At the end of the 20th century, the hospital developed a nurses training institution that hosted around 5 per cent of Ghanaian nursing students.[83] Additionally, since 1970, Agogo is a housemanship institution. In Ifakara, the lack of a training school for nurses was a problem, and only in the 1980s, when the shortage of nursing staff got out of hand, was there finally a concrete step to train nurses. It is interesting to see that this process ran parallel to the positive experience of drawing medical assistants into the hospital directly from the school in the neighbouring Medical Assistants Training Centre (MATC).[84]

Racial policies on the training of local people in South Africa represent a significant aspect within the large debates about 'Africanisation', which raged in all three hospitals during the 20th century. The black nurses trained at Elim Hospital were prevented from becoming more than nurses. But even in this field, the first black matron was only appointed in 1978 after pressure came from the Gazankulu Government. Yet, this was six years before the first Tanzanian became matron in Ifakara. It was actually in the mid-1980s when top-level medical staff in Ifakara became 'africanised', and not before 1993 did an African take the job of Medical Director – still working with a recently appointed expatriate hospital administrator. At Agogo Hospital, senior posts like head matron and tutor of the nursing school were occupied by Ghanaians by the early 1970s. The first African doctor was seconded by the government in 1972. But at that time the management of the hospital was still held by Swiss and Dutch medical superintendents until a Ghanaian took over as the first General Manager in 1991.

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[79] Dreier: Schweizer Ordensschwestern und die Konstituierung von Fürsorge- und Pflegeidealen in Ostafrika, 1920-1990, Wien, 2011 (forthcoming).

[80] This happened in St. Francis Hospital. Interview matron of SFDDH, May 2009, but also in dispensaries (Interviews with Sr. Ruth; with Sr. Josephata, Dar es Salaam, 2009&2010).

[81] Nouvelles de nos missions médicales, 1934.

[82] From then on, as a national training, QRN training was replaced by the shorter Enrolled Nurse training. See: Presbyterian Church of Ghana, "Report for 1969," 1970, 54.

[83] Figures from the Ministry of Health (www.moh-ghana.org).

[84] The MATC goes back to the foundation of the Rural Aid Centre in Ifakara that started to train rural medical staff in 1961. This was not nursing staff but meant to be in charge of rural health institutions.

The slow entry and access of African professionals into the top-positions of the health institutions hints, very generally speaking, at the limitations that professionals experienced in their scope of action. While expatriate doctors often were nervous about the slow progress that professional training made in the African countries, a look at the careers of health staff in the hospitals shows that career-wise it was certainly better to assimilate cosmopolitan discourses of 'medicine in developing countries' than to challenge its boundaries.[85]

Patients

The relationship between patients and the institution has been difficult to analyse. The large majority of patients are at best numbers in an annual statistic or subject of anecdotal accounts by the European hospital staff.[86] But the case study on Elim Hospital has been able to identify a body of letters written by patients, in which the relationship between the physician and the patient becomes visible. This case study has also helped to understand how patients could influence managerial decision-making.[87]

While for most of the time, the health care institutions created this category by the services they provided (see section above on health institutions). Patients contributed to the income of the hospital and their willingness (and ability) to pay for medical treatment was crucial for the financing of the hospital. From this point of view, the 'successful' and 'popular' curative services were the demand that the hospital had to cover. Furthermore, white patients in Elim Hospital had an influence on service provision: they complained about being kept too close to Africans, having to pay for services given to Africans, and eventually pressured government to build a whites-only hospital in Louis Trichardt. As in Elim Hospital, the sources on Agogo Hospital give a picture of the importance of 'better off' patients for the early period. E.g. in 1934 the physician Carl Huppenbauer reported that, due the decreasing cocoa prices during the 1930s depression, calls at the hospital declined constantly. Especially problematic was, according to Huppenbauer, that the (economically speaking) 'most important' patients did not come from the 'backward' ('rückständigen') Ashanti, but from the colony, where 'Basel' had a good reputation. Now these people did not have any money for the long journey.[88] The 'first class patients' at Agogo Hospital in the 1930s were, apart from Europeans and rich Africans, nobles and officials from Kumasi, including the Asantehene Perempeh II. Such individual patients, with the influence deriving from their position, supported from time to time the hospital in their interests, but also promoted their own interest vis-à-vis the hospital management (or the mission/church).[89]

The views of other patients are much more difficult to grasp in the sources. The Swiss Capuchins were rather 'quiet' about the patients in the private ward – who were too important for the income of the hospital and surgeon – and it was rather the latter who advertised the hospital to private patients.

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[85] Doctors with a steep career path inside St. Francis Hospital received sponsorships for training in pediatrics, community medicine or public health. In the end, however, a specialist surgeon from outside was appointed Medical Director. Never did any healer trained in 'traditional medicine' get posted in St. Francis Hospital.

[86] There is an absence of patient files usable for historical analysis in St. Francis Hospital.

[87] DMR Archives Lausanne. 5.1. Hôpital d'Elim. 7. Rapport sur la situation de l'hôpital d'Elim, 1919, p.1.

[88] D-4-6-2, Huppenbauer vor Komitee, 14. Feb. 1934.

[89] E.g. in the 1930s the Asantehene Prempeh II 'negotiated' for Agogo about land with the Agogohene, but also asks the Committee in Basel to send a specific physician back to Agogo. See Mahiya Palace Archives, Kumasi (MAG), 2/2/2/1: "Asantehene to Agogohene," February 20, 1937; ibid., "Asantehene to Agogohene," November 26, 1938, MAG2/2/2/1, Manhiya; "Hartenstein to Perempeh II," November 20, 1937, D-4-7,3, Basel Mission; "Asantehene Perempeh II to Rev Hartenstein," October 13, 1937, D-4-7,3, Basel Mission. In 1956 the President of the Kumasi Town Council lobbied for a better road between Konongo and Agogo; see: Hans Meister, "Jahresbericht 1956," 1957, PS1-B05-03-10198, Basel Mission.

It was hardly possible to collect good material on patient's experiences while they were in the ward. At least, our study shows that there are different categories of patients: most prominent in the sources are those patients who arrived because of the specialisation and fame of the hospital: treatment of hernia in St. Francis Hospital from the very beginning of the work of Dr Schöpf, or eye diseases in the case of Elim and Agogo Hospital. It seems that such special groups of patients have been in the institutions for a very long time, tuberculosis and leprosy are such examples – and these patients must have transformed life in these wards or even leprosy villages more than those patients who received treatment at the out-patient departments. The last example again makes it clear that there were a lot of patients outside the hospital, former patients who must have told their experiences to others. However, we found hardly any data on this, and where we have it, as in interviews with patients, we have not yet finished to analyse it.

State: Colonial, Independent, Apartheid

This research has shed light on how a state could play different roles within the framework of health service delivery over the 20th century in Africa. For most of their history, mission and church health services were not independent. Mission services could be seen as subsidiary to the government health care system. There was an early phase of relative autonomy of mission medical work when missions depended on the allocation of land and the tolerance of the state for activities of its members (who certainly walked the thin line of quacks). The general trend, however, saw the state assuming more control over health policies in the hospitals and dispensaries. This steering hand of the state, by means of health and development programmes, was felt most strongly in the daily work of the church health institutions in Ghana and Tanzania from the 1960s and 1970s respectively. In Tanzania, and contrary to the situation in Apartheid South Africa, this trend was to some degree reversed in the 1980s, when for example the Tanzanian states seemed almost bankrupt, but through programmes like national PHC programmes still functioned as major gate-keepers for money from bilaterally and multilaterally funded development – but by that time national and developmentalist concepts had already been firmly established in the church health services (see next section).

Seen from a state perspective, the colonial state had cooperated with the missions in health care provision since the very beginning. This cooperation was a complicated affair however – we have already presented the story of secularization of Elim Hospital in the introduction to this paper. Some of the mission societies were closer to the state than others. The Capuchins' relations were quite unstable and seem to have depended on the goodwill of the state administrators: It seems that it was the missions which had to approach both central government in Dar es Salaam or the district administrator when they wanted something. In the Gold Coast, until the end of the 1940s, there was no systematic collaboration between missions and the state in the medical field or support by the state.

From the 1940s in Tanganyika, a mission medical committee, later the Christian Medical Board of Tanzania,[90] including all mission societies and then all church bodies, was lobbying the central government. But St. Francis Hospital did not play a prominent role in this organisation, whereas in South Africa the *South African Association of Missionary Hospitals* for some time was headed by the director of Elim Hospital, and in Ghana, an Agogo physician played a prominent role in the foundation of the Christian Hospital Association of Ghana (CHAG; today Christian Health Organisation) in 1967. Until today, CHAG coordinates the

[90] Tanganyika Territory Mission Medical Committee. *Extract from the minutes, January 1950*. TNA: 10409 vol II, Tanganyika Territory Mission Medical Committee. *Memorandum by select Committee on medical missions on medical policy [DSM, 30.09.1955]*. TNA 692/1 Missions-Policy.

different churches' health care activities and channels the relationship to the Ministry of Health. These organisations are good examples of pressure groups working inside or close to the state.

By the time the mission hospitals were founded in Ghana, and especially Tanzania, the state played a crucial role in the area of health care through its financial interventions. What had first started in the leprosy sector, that Government gave financial and material support (drugs, equipment), was slowly extended into a general policy. In South Africa, two levels of state funding were important: the central government funded specialized health institutions and specialized services, and the Transvaal Provincial Administration subsidised the Swiss mission hospital. Both could influence the functioning of the health institution. In all three case studies, although in Ghana not before the end of World War II, the state was important in its function as funder of health activities provided by the church; when the state started to subsidize mission doctors and sisters, it also exerted a certain gate keeping role: it controlled health professionals' registration and it made sure that a certain number of staff was present at health care delivery institutions. In South Africa, institutionalized racial policy was implemented through the state's financial power: the construction of a mission hospital in rural areas was financially supported by the state which could thus establish its political influence.[91]

The case of Agogo Hospital deserves some special attention for the role that native administration and chieftaincy played. While in Ifakara the Capuchin mission acknowledged the fact that the chief was not an 'enemy', but rather a tolerant friend of the mission, with the beginning of independence chiefly power was quickly transformed into party power. In Ghana, chieftaincy structures remained politically, socially and culturally important during British indirect rule, as well as after independence. The role they played for Agogo Hospital throughout its history is difficult to grasp, as they only appear sporadically in the mission's and hospital's sources. The official account of the Agogo Court assigns a very important individual role to the Agogohene at the time of the funding of the hospital. The established account on the motivation for this act put an emphasis on his active role in 'getting' mission and hospital (see above). Even though not much can be said about the development of the relationship between hospital and local traditional authorities, certain incidences indicate that the relationship between mission and the Agogohene's council was not always as trouble-free as it is portrayed in hindsight.[92]

In general, the government intervened directly as an expert in the field of health. Public health (including its legislation) was firmly in the hands of the state and channelled important resources in health care through national or regional programmes that were mostly disease-specific. For instance, in the 1970s the Tuberculosis Programme of the Department of Health of the Northern Transvaal Region produced many guides and pamphlets that informed the health workers and the public about their roles, and integrated health institutions' activities into a larger national trust.[93] Looking at the tuberculosis programme in Ulanga and Kilombero at the same time allows us to grasp some of the different ways in which the state operated. Here the National Tuberculosis and Leprosy Programme grew not least from an initiative that had been started in the late 1960s in the core region of the Capuchins' medical work, first by the St. Francis Hospital and then by a Swiss organisation. The 'pilot' project was welcomed

[91] This included the hospital for whites in Louis Trichardt in 1949 and the hospital, largely for blacks, at Malamulele in the late 1960s.

[92] E.g. in a conflict about a building-free zone demanded by the mission, the hospital had to count on the support of the Asantehene. "Asantehene to Agogohene."

[93] Elim Hospital Archives. Pamphlet n. 5, 1972. What is Tuberculosis?; Annexe 2. Duties and functions of the members of health team for approved preventive and promotive health services. Medical Officer; Public Health Nurse; Sister; Staff Nurse; Staff Assistant male and female.

by the Tanzanian state, but it soon became clear that neither the Swiss nor the Tanzanian state was capable of sustaining the implementation of this work on a national scale. Staff, transport and communication were scarce and Tanzania had to find other donors interested in this programme.[94] Finally, in the 1980s, when even more programmes had been piloted and then taken over by the state, the state was not only acting through its presence, but also through its absence: by not paying salaries and not delivering drugs and equipment, the deficiency of state power was driving the development of the health system in a particular way: not by being the strongest actor, but by being essential, but weak.[95]

Some synthetizing conclusions of Section III:

- The state and its representatives and representations – ranging from individuals, institutions, authorities, local chiefs, administration, ministries, permits/certificates, policies, and politics to laws – were perceived and experienced by the three mission hospitals in very different ways, depending on time and place. Sometimes, the state had posed as a very coercive and bullying ruler, for example in Apartheid South Africa where Pretoria controlled the finances of the Bantustan of Gazankulu; it was not always a reliable and trustworthy partner such as in financial, policy and logistic matters; the state was during certain times a cooperative 'partner in development' (e.g. in Ghana and Tanzania) along with the missions; or it has taken on a complementary or even pioneering role to the mission hospitals (e.g. Elim and Agogo Hospital); the state very often performed a direct control over the missions' activities and also policy through integrating the hospitals into its health system structure or through granting professional certificates (e.g. in St. Francis Hospital); it has formulated and framed binding health policies; it has attended as board member the hospital's decision-making dynamics and has striven for annual accountability – and sometimes it was also simply absent! In short, this pluralistic and rapidly changing image of 'the state' made it difficult for the missions and their hospitals to figure out and anticipate the state's stance in the medium and long term, most notably after independence.

- The patient and his/her view were for a long time a missing link, and unnoticed and voiceless part, in (the history of) the mission hospitals' health care systems – and we imagine also in the everyday work of these hospitals. As a matter of fact, the hospital administration produced a lot of patients' files and records, for instance in Elim and Agogo Hospital, but the hospitals did not take much into account – purposely or not, we do not know – the patients' perception and experience as well as the patients' socio-economic, ecological and cultural contexts. In fact, the provider's view has to a great extent shaped and dominated the development of the three (Swiss) mission hospitals over the years while the patients' understanding of hospital structure, sickness, medicine, therapy and diagnosis as well as their notion of hygiene, sanitation and wellbeing did not much influence the mission hospitals' direction and policy orientation. The important question that we are therefore not yet able to answer is whether patients' lives were driven and shaped by historical structures – or whether they occurred in independent ways and along diverse tracks.

- The education of hospital medical professionals represents one very important and meaningful activity and task, which was implemented by all three mission hospitals, in

[94] See documentation on the tuberculosis project in different accessions in BAR E2025(A) t.311 Tanzania 32.

[95] Final reports by doctors to SolidarMed in the late 1980s in ASML. For a general argument on this in the case of Tanzania see: Aili Mari Tripp, *Changing the Rules: the Politics of Liberalization and the Urban Informal Economy in Tanzania* (Berkeley, 1997). See also the work of the health economist Lucy Gilson on Kilombero, e.g. in L. Gilson, M. Alilio, and K. Heggenhougen, "Community satisfaction with primary health care services: an evaluation undertaken in the Morogoro Region of Tanzania." *Social Science and Medicine* 39(6) (1994), L. Gilson and J. Rushby. *Recurrent Cost Analysis of Selected Patient Care Centres in SFDDH, Ifakara, 17.06.1991*. ASML: R3T6O1quer Vor 94 Diverse Berichte Tansania SFDDH.

particular the education and training of nurses. This work has not only shaped the sense of a 'corporate identity' – 'I belong to the mission hospital staff and I am proud of it' – and produced a certain level of professional systematization and standardization (e.g. of quality of care), but was also one of several important issues as regards 'africanisation'. African nurses and doctors – and not only African gardeners and watchmen – had not only a strong symbolic meaning in 'contextualising' mission institutions, but were also essential indications of nation-building dynamics and of becoming part of the nation's efforts for development, in particular in Ghana and Tanzania. Nevertheless, and as a rather surprising fact because of this long-lasting 'tradition' of education and training of local staff (particularly in Elim Hospital), the takeover process of crucial positions in each of the mission hospitals was a very slow and burdensome transformation, which did not happen without external secular pressure from regional, national or even international authorities. The reasons for this deceleration were manifold, ranging from strict Apartheid laws, doubts about the locals' professional quality to immanent gender-race inequalities (i.e. white male doctors and management – African female subordinates). But when we look back and assess the strengths of each of the studied mission hospitals, medical and paramedical education and training of local persons have contributed fulsomely to the very good reputation and professional excellence of the three mission hospitals up to now.

- 'Health sells well!' is certainly the complete reversal of the original mission message of 'The Good Samaritan and his Christian grace of charity' during the formative years of the three Swiss hospitals. But it certainly reflects the wide ideological scope between the first years after the hospital's foundation and the modernistic developmental era in the late 1970s and 1980s. The latter brought new actors with new ideas and objectives: experts, consultants, aid workers and volunteers, financed and sent by private or public donors and funders – and with them the first scientists and researchers (particularly at St. Francis Hospital). This crucial transformation from humble spiritual centre of healing and blessing to a prominent development project was a significant step towards not only secularization, but also towards modernisation, internationalisation and scientification. The rationality of 'modern' project management has introduced new empirical, non-religious 'values' such as planning, monitoring and evaluation: the mission hospitals have finally become 'health projects' executing 'health programmes' which are 'sold' on the secular and spiritual, as well as private and public, market created by donors in Switzerland and elsewhere. Moreover, two of the three mission hospitals were located in prominent 'developing countries', namely in Tanzania and Ghana, and were thus well positioned to attract donors and funders – due to their good reputation and excellence in the health sector – in order to cover their own needs. Progress in the biomedical struggle and fight against infectious diseases in Sub-Saharan Africa has fostered this preference for well-structured and 'clean' mission hospitals with high discipline at work and good quality of care as new bases and centres of health programmes. Through this cooperation, partnership and participation soon became new conceptual frameworks which have shaped these new modes of 'technical and rational' relationships between the African mission hospitals and their foreign donors. Yet, it is a surprising fact (as the three studies have shown) that all three mission hospitals still represent to a certain extent an institution of the church and preserve major characteristics of their origins as missionary institutions. How far the 'Swissness' is still represented in the three mission hospitals is part of our on-going analysis; as is the influence on Swiss health systems of doctors and nurses who return home after long years in these African hospitals.